U.S. LAUNCHES NEW WAR ... ON OBESITY - *CENTERSPREAD*

High-Tech Health Care Pages 12-14

Health Care News

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Photo: Joe Burbank

Jorge Robinson, right, 82, talks to Dr. Peter Garcia at the Orange County Medical Clinic in Orlando, Florida. Some clinics provide free medical care for people who are uninsured. Congress is looking for a solution to the growing number of uninsured.

Helping the Uninsured Who Need it Most

BY MERRILL MATTHEWS

The economic slowdown will result in an estimated 1 million people losing their health insurance in 2002. Health insurance premiums are rising about 15 percent on average, with many individuals and businesses seeing increases of 30 to 40 percent.

Congress and state legislatures are looking for a solution to the problem of the growing number of uninsured. Fortunately, there is one, and it is gaining bipartisan support.

Employer-Based Health Insurance

The U.S. has an employer-based health insurance system. About 90 percent of Americans under age 65 who have private health insurance get it through their employer. The other 10 percent purchase health insurance on their own in what's referred to as the "individual market," much as people purchase their own auto and life insurance policies.

America has an employer-based health insurance system largely as a result of the tax code. People don't pay taxes on the money employers spend on health insurance—a significant tax-free benefit for higher-income workers and those who work for companies that purchase expensive health insurance policies.

The self-employed can take a tax deduction for health insurance they purchase for themselves. But Americans who work for employers that do not provide health coverage must buy their own, with after-tax dollars. Unfortunately, these tend to be lower-income workers who find it difficult to afford a health insurance policy.

Bipartisan Support for Tax Credits

To address this problem, there is a growing bipartisan consensus for providing a health insurance tax credit—deducted directly from the amount of taxes owed—as the fairest and most efficient way to provide a tax break to

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Grassroots Activists Take on Rx Limits

From Maryland to Oregon, citizens strike out against supplemental rebates

BY DIANE CAROL BAST AND JASON M. THOMAS

Grassroots activists converged on the capitol steps in Annapolis, Maryland on April 3 to protest the General Assembly's consideration of measures that would restrict the availability of prescription drugs.

The rally, sponsored by Citizens for a Sound Economy (CSE), drew scores of Marylanders from across the state. Chanting "politicians make lousy doctors," they protested against plans to impose price controls on prescription drugs and limit their availability to Medicaid beneficiaries.

Prior to the rally, activists heard from State Senator Alex Mooney (R-Frederick), who warned that the prescription drug controls advocated by State Senator Chris Van Hollen (D-Montgomery) and State Delegate Rushern Baker (D-Prince George) would have unintended consequences and could increase overall health care spending in the state.

Restricting Rx Availability

Since 1990, federal Medicaid law has required that pharmaceutical firms provide each state's Medicaid program with all of its drugs at the lowest price available in the state, or at a 15.1 percent discount off the average manufacturers' price, whichever is lower. Now, state legislatures across the country are considering "supplemental rebate" measures that would require the drug companies to discount their products even more deeply. (See "States Declare War against Prescription Drugs," *Health Care News*, April 2002.)

Maryland's supplemental rebates proposal would require an additional 10 percent discount from manufacturers who want their drugs placed on the Medicaid formulary—the list of drugs approved for Medicaid patients. Firms unwilling or unable to offer the additional discount would be effectively barred from the Medicaid market, which represents between 9 and 13 percent of the overall market for pharmaceutical drugs in Maryland.

Three states—California, Florida, and New Mexico—have already adopted supplemental rebate programs. Many others are considering them.

Hidden Taxes

In late February, the state director of CSE's North Carolina chapter testified against prior authorization and supplemental rebate programs pending before the state legislature.

"Prior authorization and supplemental rebates

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Bioterror Act Creates Its Own Terror

BY CONRAD F. MEIER

In the wake of September 11, the Centers for Disease Control (CDC) recommended states adopt a model law creating sweeping new government powers to address public health emergencies. The Model Emergency Health Powers Act, or MEHPA, has created a storm of protest across the country.

The legislation would grant governors unchecked authority to declare a state of emergency. A governor's decision to declare an emergency could not be reviewed for 60 days after the declaration. Moreover, government officials would be authorized by the proposal to obtain and disseminate personal information about a

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Tom Scully Defies Congressional Subpoena

BY CONRAD F. MEIER

Tom Scully, administrator of the Centers for Medicare and Medicaid Services (CMS), defied a congressional subpoena to appear on April 10 before a House committee to discuss the effect of Medicare regulations on small businesses. Small Business Committee Chairman Rep. Donald Manzullo (R-Illinois) immediately demanded Scully resign his position.

The House Small Business Committee had called Scully to testify about whether Medicare regulations have hurt small businesses marketing medical devices, such as portable x-ray machines. Committee members want to know more about CMS regulations that reduced payments to providers of such portable diagnostic equipment.

The suppliers of portable diagnostic equipment serve nursing homes and similar facilities by taking the equipment there, allowing x-rays and EKGs to be performed at a patient's bedside. Several physicians have said low Medicare reimbursement rates are forcing small companies out of business.

Ready to Testify

Scully said he arrived on Capitol Hill shortly before the scheduled hearing fully intending to testify until he read the witness list, which included representatives of industry groups affected by low reimbursement rates.

Scully told committee staff members he would not appear at the hearing with individuals from the companies he regulates. He did, however, submit written comments to the committee.

Scully said he would address the committee separately and would listen to testimony from the other witnesses, but would not "mix it up with people who have a gripe about a particular regulation." Scully maintains congressional "courtesy" and "tradition" should allow him to testify "free of interference" from other witnesses.

Checking with the Boss

Scully decided not to appear before the committee after consulting with HHS Secretary Tommy Thompson and department counsel Alex Azar. "The department decided this was the right thing to do. There was no precedent for the department to testify on a panel with people we regulate," Scully told the *New York Times*.

Scully's office had balked at the administrator testifying on the same panel as industry and advocacy groups, many of whom are upset over Medicare funding regulations. The hearing was to have dealt with a 1980 law known as the Regulatory Flexibility Act (RFA). The RFA requires agencies to take into consideration the impact of rule-making on small businesses before regulatory actions are taken. The Small Business Administration has ruled the reduction in Medicare reimbursements violates the RFA.

> **"If he thinks he's too good to sit with taxpayers, he does a disservice to every medical provider and recipient of Medicare and Medicaid."**
>
> **REP. DONALD MANZULLO (R-ILLINOIS)**

Zachary Evans, chairman of the board for the National Association of Portable X-Ray Providers, told the hearing committee, "The CMS refuses to consider the impact on our industry."

Resignation Demanded

Scully's decision not to testify prompted Manzullo to demand his resignation. "I asked for his resignation," Manzullo told *Congressional Daily*, "because if he thinks he's too good to sit with taxpayers, he does a disservice to every medical provider and recipient of Medicare and Medicaid."

Manzullo added, "Anybody who refuses ... to work out problems affecting people's lives shouldn't be in public service." Manzullo said he is considering several options to deal with the situation, including holding Scully in contempt of Congress. Manzullo went so far as to say that by the time his committee meets again, the CMS may have a new administrator.

Any official action against Scully would require a full House vote.

Increasing Medicare Payments

In further House action down the hall from where Scully was to have testified, Reps. Jerry Moran (R-Kansas) and Jim Turner (D-Texas) introduced a bill to increase Medicare payments to rural hospitals.

Currently, only a limited number of rural hospitals—those with 15 or fewer beds—are eligible for Medicare's Critical Access Hospital program. Moran and Turner's Rural Community Hospital Assistance Act (RCHAA) would extend eligibility to hospitals with as many as 50 beds. Additional medical services would also become eligible for Medicare support.

The Critical Access Hospital program, established under the Balanced Budget Act of 1997, grants full Medicare reimbursement for the costs of services provided by hospitals qualifying for Critical Access designation.

The RCHAA, if passed into law, would cost an estimated $2 billion over five years.

Moran and Turner also joined the growing number of people critical of a provision in President George W. Bush's fiscal year 2003 budget proposal requiring any Medicare provider payment increases to be offset by decreases to other providers, such as specialists who provide portable diagnostic equipment.

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The Pulse

Free-market health care reform in the news

BY GREG SCANDLEN

You are invited to participate in an online discussion list dealing with many of the issues we report on here. To check it out, send an e-mail to HealthBenefitsReform-subscribe@yahoogroups.com. Later on, if you want to drop off, just send an e-mail to HealthBenefitsReform-unsubscribe @yahoogroups.com.

Pluses, minuses of consumer-driven care

Jamie Robinson, a professor of health economics at Berkeley, is rapidly becoming one of the more highly regarded health economists in the country.

He has an article in the March online version of *Health Affairs* titled "Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design." It is not an easy read, but it is an important contribution to the literature.

Robinson acknowledges some of the downsides of consumer-driven health care, but carefully weighs them against the advantages. Importantly, he notes the difference between "supply-side" controls embodied in managed care programs and the "demand-side" controls of consumer-driven approaches. He examines four "challenges for health policy":

- Risk selection. He agrees it will happen but suggests the problems it creates in the real world are overstated.
- Administrative complexity. He agrees there is an administrative cost to having a wide selection of choices, but argues Americans have always been willing to pay that cost to avoid uniformity of products and services.
- Cross-subsidies. While costs may rise for some, he says, "forcing the poor to purchase comprehensive insurance while forgoing goods and services to which they attach a higher value is not doing them any favor."
- Financial barriers to access. While "it is to be assumed that substantial cost-sharing will lead to some adverse outcomes for some patients resulting from forgone care," he says cost-sharing also provides an opportunity to entice patients into more strictly managed care programs to avoid those added costs.

In the end, Robinson says, the system-wide benefits of the "bottom-up health system reform" that consumer-driven care will foster are well worth the costs.

Source: http://healthaffairs.org/WebExclusives/Robinson_Web_excl_032002.htm

Friedman: Third-Party Payment Is the Problem

While we're looking at scholarship, you might want to review an article by Milton Friedman in *The Public Interest*, published a year ago. Titled "How to Cure Health Care," the article can be summed up in one short quote:

"The high cost and inequitable character of our medical care system is the direct result of our steady movement toward reliance on third-party payment. A cure requires reversing course, reprivatizing medical care by eliminating most third-party payment, and restoring the role of insurance to providing protection against major medical catastrophes."

Friedman calculates that we spend over twice as much on health care as we would have without such reliance on third-party payments. After examining health indicators such as changes in life expectancy before and after 1950, he adds, "it is hard to see that we have gotten much for that spending other than bureaucratization and widespread dissatisfaction with the economic organization of medical care."

Source: http://www.thepublicinterest.com/archives/2001winter/article1.html

Senate Republicans Agree

I was reminded of the Friedman article by a short piece issued by the U.S. Senate Republican Policy Committee (RPC). The article responds to one by Drew Altman and Larry Levitt of the Kaiser Family Foundation (KFF) in *Health Affairs*. Altman and Levitt say, in essence, "Golly, nothing we've tried over the past 35 years to hold down health care costs seems to work."

The RPC responds, "All past efforts failed because they did not address the principal reason for escalating health spending: third-party payment." It includes links to the Friedman article as well as to the KFF article.

Source: http://www-senate.gov/~rpc/releases/1999/hc032602.htm

CMS: Third-Party Payment Keeps Increasing

Related to Friedman's hypothesis is a new report released by the Centers for Medicare and Medicaid Services (CMS) on national health expenditures (NHE).

According to the report, direct payment for services continues to drop as a proportion of total national spending. In 2000, only 15 percent of total NHE was paid directly out-of-pocket, while 45 percent was paid by government and 40 percent by private third-parties.

In 1980, the figures were 28 percent out-of-pocket, 40 percent government, and 32 percent private third-party. In 1960 it was 56 percent out-of-pocket, 21 percent government, and 23 percent private third-party.

Small wonder health care costs continue to escalate.

Source: http://www.hcfa.gov/stats/nhe-oact/hilites.htm and http://www.hcfa.gov/stats/nhe-oact/tables/chart.htm

Dallas Morning News Looks for Solutions

All this talk about rising costs is no mere abstraction to employers, who have to pay the bill to maintain the system of third-party payment.

Writing in the *Dallas Morning News*, J.C. Conklin tries to offer employers some practical advice on controlling costs. She talks to Helen Darling of the Washington Business Group on Health (WBGH), who recommends programs like disease management and tiered drug schedules, though Darling also says, "Some (disease management) programs just send out little brochures on diabetes, others are much more active." She says employers should invest money to make sure they have a quality program.

The article also mentions interest in "consumer-driven models" but notes some critics say "these plans are just a fancy way to cut benefits." Conklin also quotes me as saying employers should inform workers what all this costs and allow workers to cash-out of the plan.

Source: http://www.dallasnews.com/ The article ran on March 26, 2002. You have to register to access it.

Atlanta Business Chronicle Does Too

In the *Atlanta Business Chronicle*, Julie Bryant is even more colorful. She writes that employers "are gingerly piling more health care costs onto employees and redefining the notion of health benefits ..."

She documents local information on the rising cost of benefits and quotes Emory University's Ken Thorpe as saying, "There has been a major transition in health care. The old tools used to control costs are no longer accepted. ..." The question, then, is what's next? Bryant doesn't have a lot of answers, and when she does come up with some, like medical savings accounts and defined contribution, she allows Paul Ginsburg of the Center for Health Systems Change to downplay them, saying he doubts these will become "widely popular."

Source: http://www.bizjournals.com/atlanta/stories/2002/04/01/smallb1.html

Columbus Paper Likes Defined Contribution

The *Columbus Ledger-Enquirer* covers some of the same ground in an article by Chuck Crouch. He says, "health care is going through a critical transformation" and adds, "The move is toward defined patient-controlled plans."

Crouch lists five elements of these patient-controlled approaches: Cash, vouchers, health promotion accounts, health savings accounts, and community health care cooperatives.

Crouch quotes Wayne Anthony of the Business Resource Center as saying the cash and voucher approaches are already in use by about 5 percent of the "nation's major employers." He expects that to rise to 20 percent next year. The other approaches need legislative action before being implemented, he says.

Source: Go to http://www.ledger-enquirer.com The article ran on March 22, 2002.

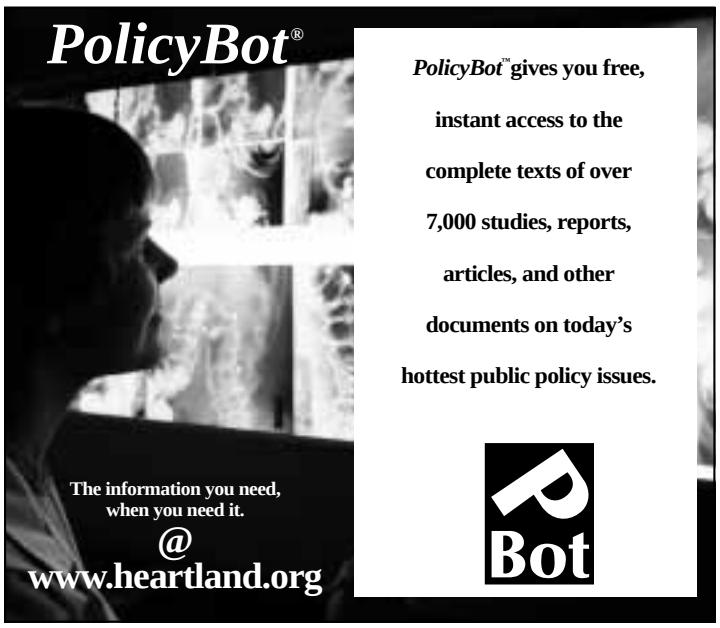
Towers Perrin Dips Oar in Defined Contribution Waters

Towers Perrin has been late getting an oar in the defined contribution water, but they try to make a dent in a recent news release. They try to position themselves less as true believers and more as hard-headed business analysts. Senior consultant Michael Taylor is quoted as saying, "employers should carefully consider whether these plans will positively or negatively impact their overall business needs from a cost, quality, and employee relations perspective." (Sounds like a job for a consultant, eh?)

Taylor goes on to say, "The bottom line is that defined contribution health plans have the potential to help some companies control costs, but without careful positioning and pricing, they may lead to increased costs for others."

Source: Contact Stanley Davis at Towers Perrin for a copy, 914/745-4191, or davissw@towers.com.

Greg Scandlen is senior fellow in health policy at the National Center for Policy Analysis in Dallas, Texas and assistant editor of Health Care News. *To sign up for his free weekly e-newsletter,* Scandlen's Health Policy Comments, *log on to www.ncpa.org/sub. Email Scandlen at GMScan@aol.com.*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Bush Loosens up Privacy Rules

BY CONRAD F. MEIER

The Bush administration has proposed changing some of the federal rules designed to protect the confidentiality of medical records, including the ability of patients to decide in advance who should be able to use their personal health information.

The Bush proposal would eliminate the requirement that patients give written permission before their records may be disclosed to doctors, hospitals, pharmacies, and insurance companies. Instead, the Bush rules would require only that patients be notified of their privacy rights at some point by those who use their records.

The Bush rules would also make it easier for parents to discover what medical services their teenagers seek, and researchers would find it easier to gain access to patients' records. Business associates of various health care providers would be given more time before they have to comply with the confidentiality rules.

"The revised rules were warmly embraced by the insurance industry. ... [But] privacy advocates, physicians, and some Congressional leaders were far less accepting of the Bush proposal."

In one respect, the administration is suggesting a significant strengthening of privacy rights, by allowing patients to decide up front whether to allow their records to be used for marketing purposes.

Aimed at Improving Access to Care

The proposal represents President George W. Bush's effort to address an issue that has dogged Presidents and lawmakers for years: How much control to give consumers over access to medical records in an electronic age.

As reported in the June 2001 issue of *Health Care News*, Bush had announced he would move ahead with the medical confidentiality rules adopted by former President Bill Clinton—but indicated he would modify some of those rules to make them simpler and less onerous for health care companies and practitioners.

In disclosing what form those modifications will take, Health and Human Services (HHS) Secretary Tommy G. Thompson is now saying, "The changes we are proposing today will allow us to deliver strong protections for personal medical information while improving access to care."

The rules do not require congressional approval.

No Shortage of Critics

Bush's revised rules were warmly embraced by the insurance industry. "It's a major step toward creating a workable rule," said Karen Ignagni, president of the American Association of Health Plans. She and other insurance industry representatives would like the administration to go further to ease regulatory costs and give the industry time to adapt to the rules.

Privacy advocates, physicians, and some Congressional leaders were far less accepting of the Bush proposal. Janlori Goldman, director of Georgetown University's Health Privacy Project, said the elimination of advance permission "cuts the legs off the privacy regulation."

In a *New York Times* story, medical writer Robert Pear quotes Rep. Edward J. Markey (D-Massachusetts) as saying, "By stripping the consent requirement from the health privacy rule, the Bush administration strips patients of the fundamental right to give their consent before their health information is used or disclosed. The administration's proposal throws the baby away with the bath water."

The Bush administration has denied it is abandoning privacy protections. "The President believes strongly in the need for federal protections to ensure patient privacy," Thompson said.

In the meantime, the parts of the Clinton-era rules Bush agrees with have already taken effect, although health care providers will not be required to comply with them until next year. Health care providers and insurers must comply by April 14, 2003. Anyone who violates the rules after that date will be subject to civil and criminal penalties, including a $250,000 fine and 10 years in prison for the most serious violations.

The basic aspects of the privacy rules remain intact and guarantee Americans the right to inspect their own medical records kept in electronic form, determine who else has seen them, and complain when they are used without permission.

No End in Sight

The proposed changes are part of a controversy that has been bouncing around Capitol Hill for years. In 1996, as part of a broader health reform law, Congress set itself a deadline for adopting patient privacy protections, saying it had to do so within three years or cede authority to HHS.

When lawmakers missed the deadline, Clinton's aides began writing the rules, a process they finished shortly before he left office. Once Bush took over, opponents of the regulations resumed fierce lobbying, trying to capitalize on what they sensed was a more lenient attitude in the new administration toward federal regulation.

The newer proposals provide the first insight into how far Bush wants to go to address their complaints.

HHS officials, who briefed the media on condition of anonymity, said "very targeted changes" were intended to protect patients' privacy while eliminating facets of the original rules they said would interfere with patients' access to care. This reasoning essentially embraces the arguments the insurance industry has raised.

Striking a Balance

Specifically, the new rules strike a different balance in patients' control over access to their records.

While eliminating the requirement that consumers give written consent for records disclosure, HHS officials said, the proposal would strengthen the requirement for health care providers to make sure patients are aware of their privacy rights. Doctors, pharmacies, and others who use records would have to make a "good faith effort," although not necessarily ahead of time, to obtain written acknowledgment from patients that they had been told about privacy practices.

Thompson said he wanted to remove the consent requirements because he believed they could delay care. HHS spokesman William Pierce said the revision would avert the possibility that "you could have been stopped in your tracks" from getting needed treatment for failing to give permission for use of records.

Pharmacists and hospitals had expressed the same concern. Drugstores said they could not fill prescriptions phoned in by a doctor for pick-up by a patient's relative or neighbor. Hospitals said they could not schedule medical procedures until the patient had read a privacy notice and signed a consent form. The Bush proposal would also relax some consent requirements medical researchers saw as potentially harmful to advancing medical technology.

"HHS officials, who briefed the media on condition of anonymity, said 'very targeted changes' were intended to protect patients' privacy while eliminating facets of the original rules they said would interfere with patients' access to care."

The Bush administration also said it wants to make sure parents have "appropriate access" to the medical records of their children, including information about mental health, abortion, and treatment for drug and alcohol abuse. The Clinton rules, in the current administration's view, may have unintentionally limited parents' access to that information. The proposal makes clear that state law governs disclosures to parents.

Under Bush's revised rules, health care providers would still have to notify patients of their rights and the providers' disclosure policies. Patients would be asked to acknowledge in writing they received such notice, but they could receive care without the acknowledgment.

The rules, the first comprehensive federal standards for medical privacy, affect virtually every doctor, patient, hospital, pharmacy, and health plan in the United States.

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workers who purchase their own policies. Under most proposals, the credit would also be refundable, meaning people would get the credit even if they paid no income taxes.

For example, House Majority Leader Dick Armey (R-Texas) and Rep. Bill Lipinski (D-Illinois) have proposed "Fair Care" legislation that would provide a refundable tax credit of up to $1,000 for an individual and $3,000 for a family. President George W. Bush has recently proposed similar legislation.

Fixed vs. Variable Credit

Economists Mark Paul and Bradley Herring of the University of Pennsylvania and David Song of Yale University recently analyzed the likely response to a tax credit for health insurance. They looked at a "fixed" $1,000 refundable tax credit for self-only coverage when purchased in the individual market. They reported, "[We] find that 85 percent of the uninsured sample requires a subsidy of under $1,000 for the purchase of a $1,000 deductible PPO plan, while only 34 percent of the uninsured would respond to such a subsidy for the purchase of a [more costly] $250 deductible plan." That is, the authors found the take-up rate is in almost direct proportion to the amount of the subsidy.

Critics of the fixed tax credit charge some low-income families might be unable to pay the out-of-pocket difference, if any, between the amount of the subsidy and the cost of a policy. Moreover, some people with medical conditions are charged more for coverage because of their increased risk.

Mark Litow, an actuary and principal of the actuarial firm Milliman USA, in conjunction with the Council for Affordable Health Insurance (CAHI), has addressed that problem. According to the research, tax credits can be structured to meet the needs of the low-income and difficult-to-insure populations.

According to Litow, using Milliman's SimuCare econometric model, the federal government could provide a flat $800 per-person annual tax credit to subsidize the cost of a policy, or $3,200 for a family of four. Depending on a number of factors—including age, health status, geographical location, number in the family, and, perhaps most importantly, the type of policy chosen—an $800 per-person tax credit would cover between 33 and 90 percent of the cost of a health insurance policy.

Low-Income Workers

Of course, a tax credit that covered $800 of a $1,200 premium would still leave a $400 difference, which could be difficult for a very low-income worker to pay. Thus, the Litow-CAHI proposal provides more tax credit money to low-income working families:

- Workers making between $7,500 and $17,000 a year would receive an additional $560 on top of the basic $800 credit, for a total of $1,360.
- Those earning less than $7,500 a year would receive $1,380 in addition to the $800, for a total of $2,180.

This additional tax credit money, targeted to low-income workers, would make it possible for the large majority to purchase health insurance with little or no additional money out of pocket.

Persons with Preexisting Conditions

It is also important to address the challenges faced by persons who cannot qualify for health insurance at standard rates because of a preexisting condition. While most states have a mechanism to ensure people with preexisting conditions can get coverage, those persons often must pay higher premiums. For example, 30 states have high-risk pools, which provide coverage for persons denied health insurance in the private market. In most of these states, participants pay premiums between 25 and 50 percent higher than they would pay if they were healthy.

> **"[T]here is a growing bipartisan consensus for providing a health insurance tax credit ... as the fairest and most efficient way to provide a tax break to workers who purchase their own policies."**

To address this additional cost, the Litow-CAHI approach factors in an increase of between $400 and $1,090 per person per year, depending on income. Thus:

- A middle-income family of three with two healthy people and one with a preexisting condition could expect a total tax credit of $2,800 ($800 each for the two healthy members and $1,200 for the one with a preexisting condition).
- A low-income ($7,500-$17,000) family of three could expect to receive as much as $4,760 ($1,360 each for two and $2,040 for the member with a preexisting condition).

Medicaid Reform Could Pay for Credits

How much would such a tax credit program cost? Assuming the credit is going to those who do not have health insurance or are not already getting a tax break through their employer, Litow estimates the legislation would cost between $20 and $25 billion a year. If the tax credit were made available to all workers under age 65—a much more comprehensive proposal than Congress is considering—it would cost an additional $20 to $25 billion a year, for a total annual cost of $40 to $50 billion.

Were Congress to decide to include Medicaid reform at the same time it created a tax credit for all workers, Medicaid recipients could also use a refundable tax credit to purchase a private insurance policy. Including Medicaid recipients in the tax credit structure would make the reform budget-neutral: There would be no additional cost to the government.

Medicaid as currently operated is costly and inefficient. The federal government could provide current Medicaid recipients with a very generous refundable tax credit, allowing them to buy an individual insurance policy with almost no out-of-pocket costs, and still save $40 to $50 billion a year—enough to offset a new tax subsidy given to all workers, according to the Milliman USA model.

Conclusion

Creating a variable tax credit system is not without problems. For example, it would give taxpayers an incentive to under-report income in order to receive a larger subsidy. Nevertheless, a tax credit would be the most efficient way to assist uninsured Americans who do not get health insurance through an employer. And a variable tax credit would address the concerns of those who believe a fixed credit is too inflexible to help workers with very low incomes or preexisting conditions.

Prepared by Merrill Matthews Jr., Ph.D., director of the Council for Affordable Health Insurance and assistant editor of Health Care News. *A copy of the technical paper upon which this article is based is available upon request from CAHI. Contact Tom Gardner at mail@cahi.org.*

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English Health Care:

Not Your Cup of Tea

PART 4 IN A SERIES

BY CONRAD F. MEIER

There seems to be no argument when I report England's National Health Service (NHS) is in need of major surgery. The evidence is difficult to ignore: The NHS is plagued by a political bureaucracy, endless delay, low-quality care, and poor medical outcomes.

NHS vs. HMO

A study produced by the Institute for Global Health at the University of California concluded the Kaiser-Permanente HMO in the United States and Britain's NHS have similar resources, but the HMO performs substantially better. (See "U.S. HMO Beats Britain's NHS," *Health Care News*, March 2002.)

In particular, Kaiser patients have quicker access to both primary and secondary care doctors. In other words, the widely held notion that the NHS offers "universally available" care and is "remarkably efficient" may be wrong.

Comparisons between systems are always difficult, but the reviewers at the *British Medical Journal* conclude the results could not be explained away by differences in the two populations. They conclude the Kaiser HMO health care arrangement is superior to the NHS.

Kaiser may excel because primary and secondary care are better integrated and the whole system is better managed; because it has hospital stays shorter than those in the NHS; because the U.S. health care system has developed much better information technology; and because of free-market competition.

Wake Up or We Quit

As I documented early in this series, members of the medical profession, on average, were the most disenchanted with the NHS arrangement. This does not mean British consumers are any less upset with their socialized medicine. But the medicine men and women are closer to the problems, are clearly more vociferous, and make for good copy in the English press.

At the heart of the current reform debate is the Labour Party's insistence the basic cause of the NHS's failings is inadequate funding. Those who are on the frontlines of health care think otherwise.

When the Labour Party swept into power, medical professionals had high hopes for major reform. Most of them voted in favor of the ruling party believing the NHS would be better off with liberals than with conservatives. And while practitioners applauded the promises, doubt and cynicism have followed the broken word.

Late last year, the British Medical Association sent voting papers to all 36,000 General Practitioners (GPs) in Britain asking them if they would be prepared to resign from the NHS. There was a 66 percent response rate with 86 percent voting in favor of resignation.

Dr. Kevin Ilsley, a GP who works in a group practice in Bromyard, Worchester, stated, "I now say I only enjoy the first 40 hours of my working week and I don't get much pleasure out of the last 30 hours." Dr. Ilsley's workload is so heavy he has given up his duties as an assessor of GP training practices.

Dr. Anita Goraya, a GP in Friern Barnet, talks of patients' rising expectations and her frustration with the NHS. "I had a patient who came to see me about depression. Unfortunately, I am unable to refer anyone suffering from depression for counseling because there is a 17-month waiting list to see a therapist. There are few services locally and the waiting list for the few that exist is preposterous."

Dr. George Moses, from Hammersmith, says violence in the surgery room is a growing problem. "My partner," Moses explained, "was assaulted by a patient who received a jail sentence for the offence—that's how bad it was." The violence, Dr. Moses believes, is caused by "unrealistic" patient expectations.

According to Dr. John Chandy, consulting radiologist from Coventry and chairman of the Hospital Consultants' and Specialist Association, "The real danger now is that doctors will leave the NHS and do something entirely different."

Time for Reform

Liz Kendall of the Institute for Public Policy Research says she believes empowering patients with more information and genuine choice is critical to transforming the system. "It is a disgrace," she says, "that information is currently the preserve of a few well-connected members of the articulate middle-class when it should be available to all."

> **"Late last year, the British Medical Association sent voting papers to all 36,000 General Practitioners (GPs) in Britain asking them if they would be prepared to resign from the NHS. There was a 66 percent response rate, with 86 percent voting in favor of resignation."**

Drs. P. Buttar, J. Halfhide, S. Hunter, and J. Reggler of the Independent General Practitioners Association all agree with Chancellor Brown when he says, "the NHS has had its day." They urge reforms that would move the NHS towards a funding system similar to those in many Western European countries. The crucial difference, they point out, is that most European systems encourage patients to contribute private funds for their medical care. "When people spend their own money," they say, "they expect and get better quality [health care] service."

Stephen Pollard at the Centre for the New Europe writes, "One would think, to judge from the dogmatic belief in the NHS, that no country on Earth was able to provide its citizens with a halfway decent health service. Far from being the only worthwhile model, the NHS is the oddity."

Pollard points to the major difference between the British model and most of the European Union. "Contrary to mythology," he says, "spending is on a par with that on the continent. The difference is made up by additional private spending, which continental systems use to promote the choice and the competition between providers which is so missing from our antiquated system."

"The NHS will never deliver the level of health care our increasingly diverse society demands and expects," writes Nick Corble, Catalyst Change Consultants. As an advisor to a variety of NHS bureaucracies for more than 15 years, Corble admits, "I have witnessed and, to some extent, aided and abetted a succession of policy changes designed to fix that which is beyond repair."

Focus on Something Other than Funding

The greatest contribution to the debate over how to fix the NHS may be in the shifting of emphasis from funding to the root causes of NHS dysfunction. However, the dialogue must include freedom of choice, consumers' rights, and the establishment of reasonable expectations.

Can any system committed to universal coverage of a comprehensive range of free medical care be financially sustained, without bankrupting levels of taxation? The *British Medical Journal*, along with England's conservative policy analysts, argue it simply isn't possible.

In the predictable manner of rationing care to save money, prescription charges appeared soon after the start of the NHS, and coverage of long-term care has been abandoned. Writing in the *Sunday Times*, editorial writer Martin Ivens says, "[The] NHS services could never meet our expectations. From its inception it

CUP OF TEA continued on next page

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Canada's Abysmal Health Technology Record

BY NADEEM ESMAIL

The Credit Valley Hospital in Mississauga, Ontario has just added a new MRI unit; Alberta has committed itself to increasing the number of MRI units in the province by seven; and the Federal Government has allocated $1 billion of spending to increasing health technology. What is all this sudden fuss about MRI units?

The MRI machine is a relatively new device that became popular in the late 1980s. It creates images of the human body so doctors can analyze fluid movements, search areas like the brain or spinal cord for abnormalities, and diagnose muscle or soft tissue injuries. Although the machines are not cheap, they are of great value to surgeons, as none of these areas can be diagnosed with traditional x-ray based machines.

So now that Canada is investing heavily in these new, high-tech machines, will Canada be a health technology leader in the near future? Unfortunately, no.

Spending and MRI Availability in OECD Countries

COUNTRY	1998 SPENDING RANK (% GDP)	1998 SPENDING RANK (PER CAPITA)**	2000 MRI/ MILLION***	MRI/ MILLION RANK*
United States (1998)	1	1	7.6	6
Switzerland (1998)	2	2	13.2	2
Germany (1997)	3	4	6.2	10
France (1997)	4	12	2.5	18
Canada	6	5	2.5	19
Australia	8	10	4.7	11
Belgium (1997)	9	11	3.2	15
Greece (1996)	10	22	1.2	23
Iceland	11	9	10.7	4
Denmark	12	8	6.6	9
Italy (1999)	13	14	6.7	8
New Zealand (1998)	14	20	2.6	17
Austria	15	13	10.9	3
Sweden (1995)	16	16	6.8	7
Portugal (1997)	17	21	2.8	16
Japan (1999)	18	15	23.2	1
Czech Republic (1999)	19	24	1.6	21
Spain (1999)	20	23	4.6	12
Finland	21	19	9.5	5
Hungary (1999)	22	26	1.5	22
United Kingdom (1999)	24	18	4.5	13
Poland (1997)	25	27	0.4	24
Luxembourg (1998)	26	6	2.3	20
Mexico	27	28	0.3	25
Korea (1999)	28	25	4.3	14

*This rank is based on the number of machines available for every million inhabitants in the given country.
**Rankings were calculated using Purchasing Power Parity (PPP) exchange rates.
***2000 data were not available for all countries. Earlier years have been substituted where noted.
Source: OECD Health Data, 2001

Not for Lack of Spending

The country's failure as a technology leader is not due to a lack of spending. Canada spends a lot of money on health care. In fact, when we consider the percentage of GDP spent on health care, Canada is the sixth highest spender in the Organization for Economic and Cooperative Development (OECD), and the fifth highest in actual dollars spent per person. (See table.)

Despite our record for high spending, relatively few health technologies are available to Canadians. Canada currently ranks a depressing nineteenth in a comparison of 25 OECD countries for MRI availability. A number of countries that spend less than Canada rank higher in the availability of MRI scanners.

At present, Canada would have to add 161 MRI machines to place sixth on the chart, which would equal its rank in total spending as a percent of GDP. That number leaps to an astonishing 327 MRIs if we wished to place second (leaving out Japan, which has a disproportionately high number of MRI machines).

These simple facts go a long way towards explaining the alarming median waiting time of 12 weeks for an MRI scan. We simply don't have the technology available to us in quantities comparable to the rest of the OECD.

Less-Expensive Technology?

Of course, some will argue that Canada may have chosen to substitute less-expensive equipment for the very costly high-tech MRI machines. A computed tomography (CT) scanner, for example, can sometimes be used as a lower-cost, albeit lower-quality, alternative to an MRI scanner.

CT scanners generate an x-ray of a cross-section of the body (as opposed to the usual lengthwise image), which allows doctors to diagnose far more than they can with a basic x-ray, but still less than they can with an MRI. Specifically, the CT scanner is less able to diagnose problems in soft tissue or muscles.

If Canada in fact has been using CT scans in place of MRI scans to reduce costs, then Canada would rank relatively high on the CT scanner comparison in order to compensate for a relatively low ranking on the MRI comparison. Unfortunately for Canadians, this is not the case. In a comparison of 23 OECD countries, Canada's rank for the availability of CT scanners was similar to its rank for MRI scanners: a depressing eighteenth.

There can be no disputing the facts: Health technology is not available to Canadians in a quantity that compares favourably with other wealthy OECD countries.

Nadeem Esmail is health policy analyst at The Fraser Institute. He completed his B.A. in economics at the University of Calgary, and his Masters in economics at the University of British Columbia. He can be reached by email at nadeeme@fraserinstitute.ca.

CUP OF TEA continued from previous page

has been 'in crises.' At the end of the Korean War, demand had to be rationed by charging for teeth and spectacles. Today its shoddy premises, rationed drug treatment, and over-worked staff confound all our consumer expectations."

One structural change that hasn't been seriously tried and might well raise a cheer within the NHS itself would be to separate the NHS from politicians. There is a theory, which even we Americans witness almost every day in practice with Medicare and Medicaid, that the most politicized health care plans around the world perform the worst.

The desire to hold onto constituents' votes, elections every two years, constant changes to the tax code, and demand for instant gratification are features of politics that do not sit well with running a huge and complex service like the NHS or even our own Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration).

It's the Competition, Stupid

One of the first acts of the Labour government when elected in 1997 was to set the Bank of England free to determine interest rates. It was an unqualified success. Why not do something similar for the NHS? Would not free-market competition enhance quality, accountability, and consumer rights?

Alain Enthoven, the inventor of managed competition and the evolved managed care market, argues competition is needed for improvement. Even though many judge Britain's flirtation with competition a failure, supporters of competitive markets argue greater privatization has never happened. Politicians can't risk the political consequences of hospital closures—inevitable when hospitals in a setting of market competition fail to serve their customers.

Increased competition is probably not in the NHS's immediate future. But the collapse of any portion of the vast NHS empire might stimulate a return to competition, even if in a disorderly manner to start.

No Closure Here

Any good examination and analysis should bring closure to the discussion at its finish. What I thought and intended to be a series, with both a beginning and an end, now appears to me to be an unsatisfactory approach. What we have so far is a beginning with no end in sight.

The NHS is in a state of flux. On the positive side is a growing demand on the part of our British friends and their medical professionals to introduce, albeit slowly, a market-based health care system that responds to consumer demand instead of regulatory demand and introduces greater individual responsibility.

Less encouraging is the difficulty in weaning the entrenched, politically driven health care arrangement from 10 Downing Street. Giving up the political power that comes from keeping citizens trapped in a government bureaucracy will be neither easy nor painless.

The temporary solution—throwing massive amounts of tax money at problems inherent to socialized medicine—will not address the shortcomings of NHS. As such, it seems appropriate to continue this "series" on a recurring basis as the British struggle to regain their health care independence.

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Sign this Letter to President Bush!

State Emergency Health Powers Act Petition

Dear President Bush:

I am writing to voice my opposition to the Model State Emergency Health Powers Act (MEHPA) drafted by the U.S. Department of Health and Human Services (HHS) and being sent to state legislatures with a recommendation for passage.

While protecting citizens from biological and chemical attacks is a critical function of government, any laws passed to that end must take a deliberative approach in crafting effective policy without sacrificing the rights and liberties of individuals and families.

In contrast, this bill would give public health officials and governors sweeping new authority to quarantine and vaccinate individuals. Moreover, the proposal allows government authorities to ration and commandeer drugs and other items, including firearms and private property. And yet what constitutes a real or possible "emergency" is left subject to wide interpretation, leaving the governors little or no accountability.

The bill is so alarming that even state legislators are publicly opposing it. The nation's largest bipartisan, individual membership organization of state legislators, the American Legislative Exchange Council (ALEC), has published numerous concerns.

I therefore respectfully request that you direct HHS Secretary Tommy Thompson and all other officials from HHS and its divisions to desist immediately from all efforts, plans, and actions to promote and pass this bill. Further, I ask that no federal funds be used to promote or pass this bill.

Respectfully submitted,

First Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

Please fax to 520/325-4230 or go online at www.aapsonline.org.

American Association of Physicians and Surgeons
1601 N. Tucson Blvd. Suite 9
Tucson, AZ 85716-3450
Phone: (800) 635-1196

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For more information…

WWW see "Power Grab: The States in a State of Emergency," an *ALEC Issue Analysis* written by Jennifer King and released in January 2002. The document is available on ALEC's Web site at **http://www.alec.org/meSWFiles/pdf/0202.pdf.**

MEHPA continued from page 1

state's citizens, ration prescription drugs, and confiscate and destroy private property.

State officials could order citizens to be vaccinated, quarantine those suspected of having a contagious disease, take over hospitals and physicians' offices, and seize and destroy personal property deemed a threat to public health.

The CDC's proposed legislation was drafted by the Center for Law and Public Health at Georgetown and Johns Hopkins Universities in coordination with the National Conference of State Legislatures, National Governors Association, National Association of Attorneys General, Association of State and Territorial Health Officials, and National Association of City and County Health Offices.

Law Planned Before September 11

In the spring of 1990, the CDC accepted a number of applications from organizations wishing to collaborate with the agency on a variety of legal and public health projects. The applications were reviewed and scored. A proposal from Lawrence Gostin, director of the Center for Law and Public Health, received the top score, and thus CDC funding. The CDC awarded Gostin $300,000 per year for up to three years to develop his model legislation, among other projects.

Gostin began work on an effort to develop consistent public health laws across states. In the beginning, the effort was intended to address day-to-day health concerns, such as the tracking and reporting of conventional diseases.

When October 2001 brought the threat of anthrax spreading through the mail, CDC officials asked Gostin to spend two weeks writing a model state law to define the powers government officials would need in a health emergency. State governors were "clamoring" for guidance, they said. By month's end, they had a draft law in hand.

Civil Liberties, Privacy Threatened

Under the MEHPA, people who refuse medical examinations or treatment could be quarantined against their will. Law enforcement agencies and other government officials would have freer access to private medical information. Civil libertarians and privacy advocates are up in arms.

Gostin, who says he is sensitive to concerns about the law's impact on civil liberties, maintains that a balance must be struck: "You do have to face hard trade-offs between civil liberties and property rights of individuals against the collective rights of society," he says. "We do need to give up a little bit."

The proposal "puts the lives of an entire state in the hands of one person [the governor] who may or may not rise to the occasion," says Jonathan Turley, a law professor at George Washington University. Even a well-intended but poorly informed governor could make decisions with devastating consequences.

Also critical of the effort is the American Legislative Exchange Council (ALEC), a membership organization representing about 2,400 state legislators dedicated to free markets and individual freedom. Sandy Liddy Bourne, who oversees the issue for ALEC, stated in a news release, "We're talking about limiting firearms and property, taking clothing and livestock. This is not about protecting the public health."

Tommy Thompson, secretary of the U.S. Department of Health and Human Services, despite being a former ALEC member, endorsed the first draft of the MEHPA in a news release.

Jennifer King, a legislative expert with ALEC, is angered by the fact Gostin's model legislation has the financial backing of the CDC. She maintains, "It's crucial to know that the Centers for Disease Control actually funds that professor." She said Gostin's work at Georgetown and Johns Hopkins is "completely funded by the CDC from grant money that they got a couple years ago."

Gostin said his proposal has "unanimous support among all people with any operational responsibility," including the U.S. Department of Health and Human Services and state agencies, governors, legislators, attorneys general, and health officers. King, however, is not convinced Gostin has the support he claims. She also accused Gostin of being a "very strong public health, police-state-type advocate."

"It's odd that they (ALEC) would say that," Gostin responded. "For many years, I was on the national board of directors and the national executive committee of the ACLU; I was the head of the British Civil Liberties Union; I chaired the ACLU Privacy Committee for many years." He called her comment "misinformed."

Janlori Goldman, of Georgetown's Health Privacy Project, worries there are many provisions in the MEHPA that have not been carefully thought-through. For example, she notes, privacy safeguards are needed to ensure personal health information doesn't fall into the wrong hands. Supporters of the act "assume civil liberty and privacy issues will be dealt with elsewhere or in practice," she said, "but protections should be built into the law."

No Due Process

Twila Brase, president of Citizens' Council on Health Care (CCHC), a Minnesota-based public policy organization, is concerned the proposal would provide intrusive authority for purposes far beyond bioterrorism. Due process will suffer, she warns, noting:

- The act permits state officials to identify and train personnel to serve as "emergency judges" to hear citizen appeals of forced quarantine and isolation.
- If a public health emergency is declared, police officers would be placed under the authority of health department officials.
- In the event of a declared public health emergency, citizens would be required by law to submit to medical examinations, vaccinations, and quarantine against their will.
- Public health officials would be given authority to "collect specimens and perform tests on any person," even if they are healthy and have no history of exposure to disease.
- Health care professionals who refuse to conduct forced medical examinations or vaccinations could be charged under the law with a misdemeanor.
- Citizens who refuse to comply could be detained and charged with a misdemeanor.

Back to the Drawing Board

The MEHPA already has undergone revisions, though not enough to address most critics' concerns. The initial draft's definition of a public health emergency included epidemic diseases, provoking concern among AIDS activists that AIDS patients might be subjected to isolation. The first draft also threatened misdemeanor criminal charges against persons who refuse medical treatment.

The newer draft of the model act, released in March, narrows the definition of a public health emergency so it doesn't apply to known epidemics, such as AIDS. The draft also allows people to refuse medical treatment for religious or other reasons, though it warns they may be subject to quarantine if they do so.

The March draft of the plan incorporates other changes, but it hasn't quelled all the criticism. Anyone with a stomach ache and a bottle of antacid could be subject to quarantine by the state during a declared public health emergency, critics of the plan charge. Gostin maintains that's an unfair characterization of his proposal, which he says is simply an effort to help states respond quickly and effectively to bioterrorism, especially chemical or germ attacks.

Firearms, Prescriptions Scrutinized

The MEHPA has been called a confusing mix of bioterrorism law and public health law. Critics charge it is drafted in such a way as to cover many things that may have nothing to do with bioterrorism. For example, King said the MEHPA would be especially intrusive with regard to personal property, which the act defines not only as land and buildings, but also food, alcohol, and firearms.

"Firearms are an extreme public health hazard," Gostin replied, "but they aren't a biohazard and they don't, therefore, come within our act. So, I think that's a misunderstanding."

In fact, however, the MEHPA document refers specifically to firearms. The text says state officials will be given the power "to control, restrict, and regulate ... the use, sale, dispensing, distribution, or transportation of food, fuel, clothing, and other commodities, alcoholic beverages, firearms, explosives, and combustibles, as may be reasonable and necessary for emergency purpose."

The MEHPA also would require pharmacists to report any sudden or unusual use of drugs, according to ALEC's King.

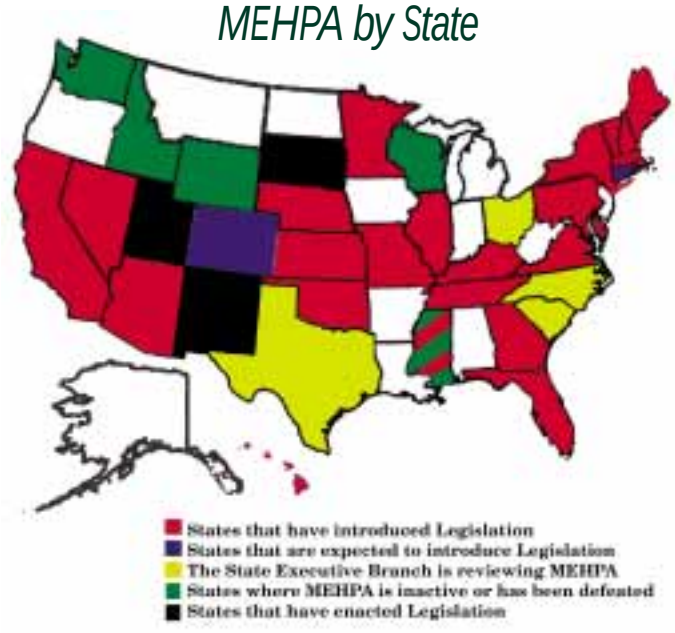
"What we've said here internally (at ALEC) is, 'What if there's some sort of a church picnic?' You always hear about the church picnic with the bad food and the run on Kaopectate." Under that scenario, King said, the MEHPA might prompt a pharmacist to alert law enforcement officials to a suspected public health emergency.

State by State

Gostin predicts his proposal will be considered in "virtually every state." He said the MEHPA is not intended to be one-size-fits-all, but rather meant to be picked over by the states and adapted by them as needed, to update laws already on the books.

State by state (see map), a battleground is emerging in state legislatures. In Illinois, for example, a measure modeled after Gostin's MEHPA was referred to the Senate Rules Committee (SB1529) in November of last year, and to the House Rules Committee (HB3809) on April 5, 2002.

MEHPA by State


States that have introduced Legislation
States that are expected to introduce Legislation
The State Executive Branch is reviewing MEHPA
States where MEHPA is inactive or has been defeated
States that have enacted Legislation

Source: American Legislative Exchange Council, January 2002

"[The MEHPA] puts the lives of an entire state in the hands of one person [the governor] who may or may not rise to the occasion."

JONATHAN TURLEY, LAW PROFESSOR GEORGE WASHINGTON UNIVERSITY

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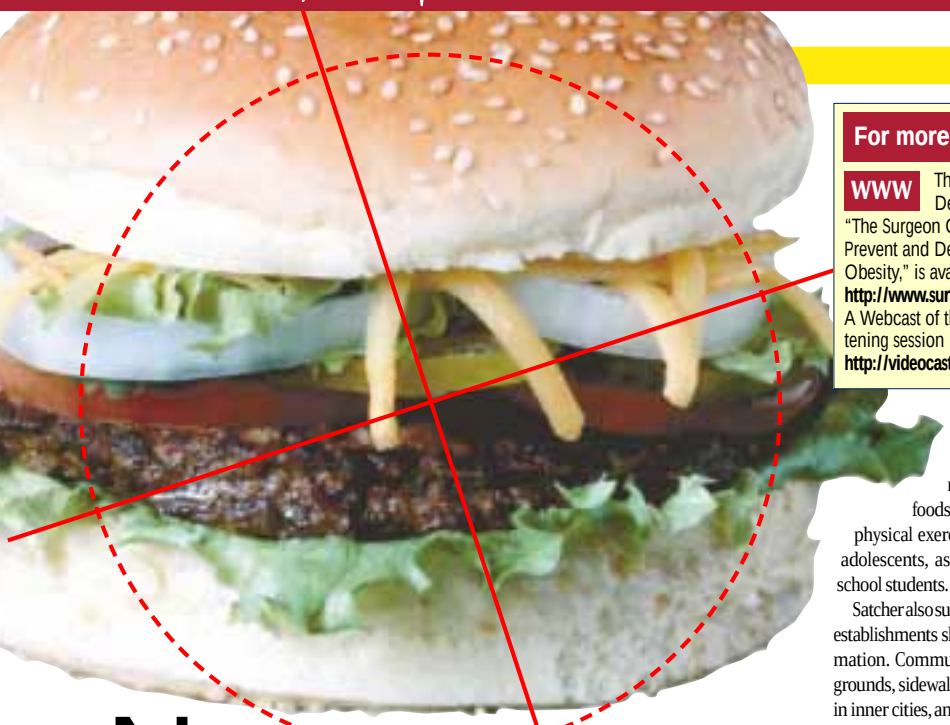

New Round Fired in Fat Wars

BY CONRAD F. MEIER AND DIANE CAROL BAST

The March/April 2002 issue of *Health Affairs* magazine offers up new ammunition in the nation's most recently launched War: not on terrorism, but on obesity.

In "The Effects of Obesity, Smoking, and Drinking on Medical Problems and Costs," Ronald Sturm, a senior economist at RAND Corp., compares the effects of obesity, overweight, smoking, and problem drinking on health care use and health status based on national survey data. Sturm directs the economic and policy research program in the UCLA/RAND Managed Care Center for Psychiatric Disorders.

Sturm finds obesity has "roughly the same association with chronic health conditions as does 20 years' aging," a link he says "greatly exceeds" the associations of smoking or problem drinking. He finds obesity to be associated with a 36 percent increase in inpatient and outpatient spending and a 77 percent increase in medications. By comparison, he says, smoking is associated with a mere 21 percent increase in inpatient and outpatient spending and a 28 percent increase in medications.

As this issue of *Health Care News* went to press, Sturm's work has attracted little press attention ... but that's likely to change. His findings play nicely into the hands of "nanny activists" seeking "Twinkie" taxes on high-calorie foods, mandatory "warning" labels on meat, food and beverage marketing restrictions, and publicity campaigns to get Americans out of fast-food restaurants.

"For years," noted the Center for Consumer Freedom (CCF), an alliance of restaurants, taverns, and defenders of freedom of choice and consumer rights, "activists who have been taking on tobacco and alcohol have also taken aim at the right to make your own dietary decisions. Now, they've dropped their bunker buster: saying an 'epidemic' calls for immediate and extreme government action."

Surgeon General Weighs In

The "bunker buster" referred to by CCF is a report issued by David Satcher, then U.S. Surgeon General, on December 13, 2001. While Satcher left the office on February 13 of this year, his report is expected to have long-term consequences.

In "The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity," Satcher declared obesity to be a "public health epidemic." He called for sweeping eating habit changes in schools, restaurants, workplaces, and communities to help combat the increase in the number of Americans who are overweight or obese.

Outlining the first national plan of action for the overweight and obesity wars, Satcher recommended schools make their lunch programs less fattening, restrict students' access to vending machines selling calorie-dense foods and soft drinks, and resume daily physical exercise classes for all children and adolescents, as well as recess for elementary school students.

Satcher also suggested restaurants and fast-food establishments should offer more nutrition information. Communities should create safe playgrounds, sidewalks, or walking trails, particularly in inner cities, and encourage physical activity.

Employers should also do their part, said Satcher. They should include weight management and physical activity counseling in their health insurance coverage and allow employees time to exercise. Satcher believes obesity should be classified officially as a disease, so as to encourage insurance companies to reimburse for weight-control expenses.

Tobacco Deja Vu

Even before *Health Affairs* concluded obesity represented a greater health threat than tobacco, the anti-consumer activists had caught on.

"Just as nobody in 1964 could conceive of restricting citizens' God-given right to smoke, few Americans today can imagine regulating something so personal as the way we exercise and eat," wrote *Self* magazine's Patti Wolter and the New America Foundation's Shannon Brownlee in *The Washington Post*. But since "obesity is epidemic, as Surgeon General David Satcher noted," we "may not have a choice."

They concluded, "It's beginning to sound like Joe Camel all over again."

John Banzhaf, professor of law at George Washington University and executive director of Action on Smoking and Health (ASH), a "how-to-sue" activist organization, agreed. "There is a movement afoot to do something about the obesity problem and see it in terms of costs."

Banzhaf told Fox News, "It's appropriate that the cost shouldn't be borne by everybody but confined to those who use the products and/or produce them." Banzhaf refers to the "total direct and indirect costs attributed to overweight and obesity," estimated by Satcher to be up to $117 billion in health-care related problems for hefty Americans in the year 2000 alone. Satcher contends approximately 300,000 U.S. deaths a year are associated with obesity and overweight.

Fact or Fiction?

Just how accurate the numbers are is anyone's guess.

According to J.D. Tucille, senior editor for the Free-market.net Spotlight, the cost estimate is an amalgamation of incomparable numbers, including health care costs handled by a variety of private insurance policies or by individuals paying their own out-of-pocket costs. "It also includes," says Tucille, "extremely vague estimates of indirect costs, including reduced productivity and lost work days resulting from obesity."

Tucille describes Banzhaf as a "professional busy body and one of the masterminds behind the lawsuits that extracted billions of dollars from tobacco companies." According to Tucille, Banzhaf "suggested fast-food chains and snack companies deserve the same treatment."

The next weaponry in what has so far been a war of words is likely to be lawsuits against corporations and government-centered schemes for modifying behavior. Among the possibilities are a fat-tax penalty for the production and consumption of supposedly unhealthy foods, a government subsidy for fruits and vegetables, and a tax deduction for staying healthy.

Brian Cohen of America's Future Foundation speculates how this latter proposal would work. "We can only imagine: Different tax brackets for different cholesterol levels? Itemized deductions for healthy food? Extra exemptions for dependents who make the traveling soccer team?"

Free-market.net's Tucille reminds us, "The ultimate 'villain' in America's epidemic of blubber has more to do with lifestyle choices than nefarious businesses peddling fattening foods. Many people eat too much of whatever they eat, and don't exercise enough. This may well harm their health, but obesity comes as a tradeoff for the pleasure that people take in eating and leading sedentary lifestyles. Some of us may not agree with that tradeoff, but we are free to make other choices."

Joseph Bast, president of The Heartland Institute, a public policy think tank in Chicago and publishers of *Health Care News*, sees dangerous parallels to the tobacco wars.

"I don't object to government officials, particularly elected ones, using their offices as bully pulpits to preach their beliefs," said Bast. "If voters don't like what they say or do, they can either vote them out of office or ignore them. But government has no Constitutional authority to use public funds or the force of regulation to impose the personal beliefs of a few on the lives of the many."

Bast warns, "A government-sponsored 'war on fat' will resemble the war on drugs, alcohol, tobacco, firearms, and other products disliked by the elite but valued by the majority. All these campaigns are sources of human suffering, public costs, and violations of individual rights that must be weighed against the slight benefits to public health they may engender."

Conrad F. Meier is managing editor and Diane Carol Bast is editor of Health Care News.

For more information...

WWW The Surgeon General's December 13, 2001 report, "The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity," is available on the Internet at **http://www.surgeongeneral.gov/topics/obesity**. A Webcast of the two-day December 2000 listening session is accessible on the Internet at: **http://videocast.nih.gov/** (requires Real Player).

The Web site of the Center for Consumer Freedom, **www.ConsumerFreedom.com**, offers a wide range of resources aimed at protecting personal responsibility and consumer choice. It includes a link to CSPInot, explaining "why the Center for Science in the Public Interest is *not* science in the public interest."

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Anti-Obesity Activists Take Aim at Food Industry

Tobacco-style litigation proposed in latest war against individual responsibility

BY CONRAD F. MEIER

The television news media has jumped on the obesity bandwagon, providing a platform for self-described consumer activists who blame the food industry for obesity.

Instead of encouraging individuals to take responsibility for their own behavior and its effect on their health, these activists suggest restaurants "should be held accountable" for the eating habits of their customers. They propose tobacco-style litigation against the food industry.

Fox News warned of "an increasingly less hypothetical lawsuit that could change the way the U.S. eats. Hungry lawyers are eyeing food, considering legal action against everyone from fast-food chains to the nation's leading snack food companies."

The Tobacco Connection

John Banzhaf, a lawyer and executive director of Action on Smoking and Health (ASH), suggests the tactics used successfully against the tobacco industry, and less successfully against gun manufactures, could be turned against the food industry. ASH paid Banzhaf $175,100 in 2000 for his promotion of "lawsuit kits" for anti-tobacco suits.

The tobacco parallel comes up again with Margo Wootan of the Center for Science in the Public Interest (CSPI). Says Wootan, "Poor diet and a lack of activity kill as many people as tobacco, but people don't think about it as being as deadly as tobacco." CSPI wants a tax on every can of soda sold.

Fish and Chips

Britain offers a preview of food-fight tactics that could be used in the U.S. Public health activists there say the economic impact of a poor diet is much greater than the impact of smoking or alcohol.

Like U.S. anti-tobacco crusaders—who painted smoking a public health threat (rather than an individual lifestyle choice) to make sure Medicare and Medicaid would cover its ill-effects—public health experts in England claim obesity is a "public health threat," straining the public health system and therefore requiring government regulation. The National Health Service (NHS) has already begun distributing drugs to control the over-eating habits of obese citizens.

U.K. experts even blame the industrialized approach to food production for obesity, claiming small-scale producers make less-fattening foods.

Fat Prohibition

In a report funded by the Robert Wood Johnson Foundation, which also funds CSPI, Deborah Cohen wrote of alcohol, "Consumption by any individual is, in part, a function of the overall distribution of consumption of the community." According to Cohen, eliminating the availability of a product to the entire community will lead to behavioral shifts that will reduce the number of people who abuse the product. Cohen has called for government intervention in the war on obesity.

That's not just wrong, it's rude, writes Miss Manners columnist Judith Martin.

"It is being said that illnesses caused or exacerbated by obesity may soon constitute the chief cause of preventable deaths, overtaking the current scourge, which is tobacco.

"Then came the plague, not just of smoking scofflaws, but of righteous busybodies. Newly empowered with public support, nonsmokers started polluting the atmosphere with unsolicited and insulting health care. Nor have they been intimidated from doing this in regard to the eating habits of those whom they deem to be overweight."

Pounding on Freedom

Responding to a Los Angeles politician's call for a full ban on smoking in public parks, Jacob Sullum of *Reason* magazine wrote, "since L.A. already has a law against littering, and tobacco smoke in the open air hardly seems like a pressing environmental concern, it seems City Councilwoman Jan Perry is interested in banning smoking only because she dislikes it.

"Perry herself says, 'When kids see adults smoking in a family-friendly place like a park, it normalizes smoking and causes it to be approved behavior.'"

What would happen if Perry's worries about "approved behavior" were "extended to other areas of public health," Sullum wonders, noting U.S. Surgeon General David Satcher's declaration of war on obesity came at the same time as Perry called for the smoking ban.

Sullum, with tongue-in-cheek, declares: "Banning fat people from public parks, where they set a bad example for the kids, is an obvious first step.

"I'm not talking about a complete ban on obesity," continues Sullum. "People would still be free to be fat in the privacy of their own homes (provided they have no children)—they would just not be allowed to go out in public until they slimmed down."

For more information…

WWW Jacob Sullum's December 25, 2001 column, "Lighten Up, America!" is available on the Internet at **http://reason.com/sullum/122501.shtml**.

Food and Drink Police

Center for Science in the Public Interest wants government to control our eating habits

BY JAMES BENNETT & THOMAS DILORENZO

There have always been ascetics and self-scourgers, and in a free society they are at perfect liberty to act (and eat) as their consciences (or bellies) dictate. But the Center for Science in the Public Interest (CSPI) is not content to use the old-fashioned and honorable tool of moral suasion.

It is not enough for them to try to convince the rest of us to renounce the "sinful" acts of devouring a bacon-cheeseburger or drinking a beer while reclining on a couch and enjoying a football game. No, the neo-prohibitionists are not satisfied with saying their piece in the marketplace of ideas. They reach for that ever-ready cudgel of the censorious scoundrel: the coercive power of the state.

As Robert Shoffner of *Washingtonian* magazine noted, "There's a political point of view here, an economic view based on the idea that people are children and have to be protected by Big Brother or Big Nanny from the awful free-market predators. ... That's what drives these people: a desire for control of other people's lives."

Meal Censors

The Center for Science in the Public Interest was founded in 1971 by a trio of self-styled consumer advocates who had worked for Ralph Nader's Center for the Study of Responsive Law.

Michael F. Jacobson, James B. Sullivan, and Jesuit Rev. Albert J. Fritsch initially pursued separate interests, including environmental pollution, nuclear energy, and nutrition. But with the departure of Fritsch and Sullivan, in 1977, CSPI turned almost exclusively to Jacobson's passion: food issues.

CSPI has found much success in its campaign to disparage "unhealthy" food. Its work became known to many consumers in 1993, when the Center began to release controversial studies disparaging Chinese, Italian and Mexican restaurants for serving high-fat and unhealthy foods.

What makes officious nannies like CSPI so maddening is that they cloak their apparent goal of prohibition in the language of health advocacy. Some of the advice in the group's *Nutrition Action Healthletter* is perfectly sensible, but the remainder can be highly controversial.

But the nannies are too canny to put the onus for "irresponsible" eating on the eaters themselves. They need bogeymen ... and who fits that bill better than business leaders? It's easier to get the prohibitionist agenda across if it is sold as an attack on business rather than people.

"Sometimes it's fun to joust with major companies," Jacobson says. Already he has taken on such giants as McDonald's, Kraft, and Campbell Soup to challenge their allegedly deceptive advertisements.

End of Privacy

To call these people "do-gooders" is to give them far too much credit. They're not do-gooders, they're bullies. And cowardly bullies at that, eager to drag in the coercive arm of the state to fight their battles for them.

When Henry David Thoreau returned from Walden Pond, he pronounced "reformers ... the greatest bores of all."

But today the reformers operate with powers Thoreau never dreamed of. We may still enjoy a dish of ice cream or a bottle of beer in our private homes, but the neo-puritans are at the door. They want in, and they want our pleasures out.

James T. Bennett is an economics professor at George Mason University in Fairfax, Virginia. Thomas DiLorenzo is an economics professor at Loyola College in Baltimore, Maryland. This article is excerpted from "Food and Drink Police: Center for Science in the Public Interest Wants Government to Control Our Eating Habits," issued by the Capital Research Center in May 1998. The full text of the article is available on the group's Web site at http://www.capitalresearch.org/publications/organizational_trends/1998/9805.htm

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Imagine Accessing Quality Health Care from the Sky!

BY DAVID CHARLES, M.D.

Imagine a woman in a rural community too small to have a first-class breast clinic, having her mammography results analyzed instantly by cancer experts at a National Cancer Institute like New York's Sloan-Kettering Medical Center.

Think of the cost savings if patients with chronic conditions—which account for 79 percent of health care spending today—could be monitored with digital connections that instantly alert their doctors to a problem.

What if two-way broadband connections would allow physicians to conduct the virtual equivalent of an office visit examination by monitoring a patient's EKG, blood pressure, and other vital signs and talking with the patient while he or she rests comfortably at home, observed by the physician through a video connection to the doctor's computer screen.

This is not Buck Rogers future-gazing. Telemedicine applications like these are being performed right now, but they are rare because getting the broadband connections means expensive private line connections and costly equipment.

I never thought I would see a prescription for high-quality, accessible health care written in the form of a merger proposal between two communications companies—but the proposed merger of satellite TV carriers EchoStar and DIRECTV is exactly that.

The combined broadcast spectrum of these two companies would allow the merged company to deliver the high-speed data capacity known as broadband via satellite to every home, hospital, and doctor's office in America. This widespread availability of broadband would finally make the promise of telemedicine available to millions of Americans.

What's Telemedicine?

Just what is telemedicine? It is the use of voice, data, and video connections to link patients with medical services they need, even if the providers of those services are hundreds or even thousands of miles away.

My own work involves implanting in the body a device that delivers a small electrical impulse in the brain to reduce the symptoms of Parkinson's disease. In the near future I may be able to "visit" a patient and adjust his or her brain-stimulating device over a high-speed internet connection.

But the lack of widespread affordable broadband connections, particularly in rural areas, is a serious stumbling block, even though telemedicine applications have proved dramatically effective where they've been tried.

This standoff between the potential benefits of telemedicine and the lack of broadband connections could end quickly if the Federal Communications Commission and the U.S. Department of Justice give their respective blessings to the merger.

> **"Denying Americans the benefits of improved telemedicine would be inexcusable when the capacity to increase those benefits is before us now."**

Any home, anywhere in America, with one of those pizza-sized satellite dishes could become an extension of a teaching hospital or specialist's office hundreds or even thousands of miles away. Small-town doctors or rural health clinics could reach out to physicians anywhere in the country to examine their patients or evaluate lab results.

Unlike so many other problems in health care, this one has a simple solution. All the government has to do is take a page from the physician's Hippocratic Oath that says: "First, do no harm."

In other words, the FCC and Justice Department shouldn't block this free-market solution to a public health problem. Denying Americans the benefits of improved telemedicine would be inexcusable when the capacity to increase those benefits is before us now.

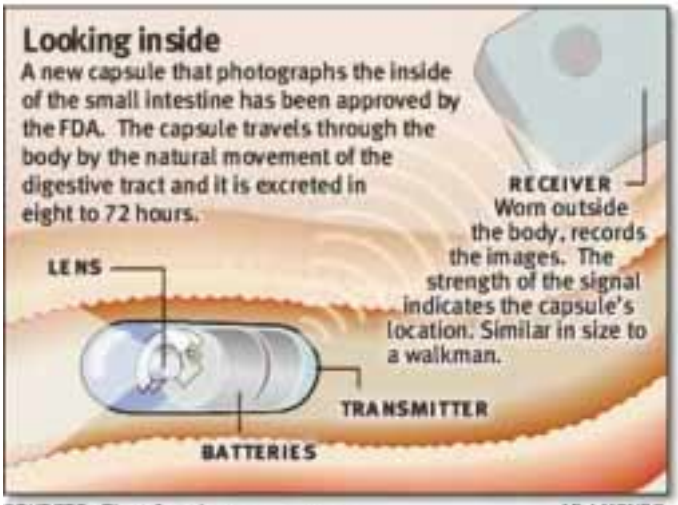
Dr. David Charles is director of the Movement Disorders Clinic at Vanderbilt University Medical Center and chairman of the National Alliance of Medical Researchers and Teaching Physicians. For more information about the Alliance, visit the Web site at http://www.medicalresearchers.org.

Smile, You're on Candid Camera-Pill

BY CONRAD F. MEIER

The Food and Drug Administration (FDA) has approved a tiny camera patients can swallow to yield a living-color tour of the stomach and bowel. The medical diagnostic technology is a camera-in-a-capsule that takes pictures as it travels through the digestive tract. The device offers a less invasive, more patient-friendly technique for detecting abnormalities in the small intestine.

The camera-pill uses wireless technology to beam back color pictures as it painlessly wends its way through the digestive tract.


Looking inside
A new capsule that photographs the inside of the small intestine has been approved by the FDA. The capsule travels through the body by the natural movement of the digestive tract and it is excreted in eight to 72 hours.
RECEIVER
Worn outside the body, records the images. The strength of the signal indicates the capsule's location. Similar in size to a walkman.
LENS
TRANSMITTER
BATTERIES

SOURCES: Given Imaging; Webster's New World Dictionary of Science

AP / MSNBC

FDA Moved Fast

A study of 57 healthy people who swallowed the camera-pill found it safely passes through the digestive tract. In a study of 20 patients with intestinal abnormalities, the pill was found to be 60 percent effective in uncovering those abnormalities. By contrast, just 35 percent of abnormalities were diagnosed using the traditional method, a somewhat uncomfortable procedure where tubes fitted with tiny cameras, called endoscopes, are inserted down the throat to look at the small intestine.

In uncharacteristic fashion, the FDA allowed small studies of the camera-pill to go forward because the technology is similar to today's endoscopic cameras, just in pill form instead of mounted on a tube. In an announcement approving the pill, the FDA stated it should be used in conjunction with traditional endoscopic tests, not as a stand-alone exam.

The camera-pill is disposable, excreted eight to 72 hours after being swallowed. Before it is expelled from the body, it will have beamed high-quality pictures to an external receiver the patient wears on a waistband.

Sci-Fi Health Care

Dr. Blair Lewis of New York's Mount Sinai School of Medicine, in news reports by The Associated Press and Reuters, said, "It's very sci-fi, and initially when the people from Given [Imaging Ltd., the firm that manufactures the camera-pill] approached me two years ago I didn't believe it."

Lewis has since tested the video pill on 20 patients and determined it works.

"I have been shown to be wrong—it is believable and shows tremendous promise," Lewis said. He estimated that many of the nearly 25,000 people with internal bleeding of undiagnosed causes might be candidates to try the camera-pill.

The camera-pill can take pictures of the small intestine, a 20-foot-long "blind spot" for current diagnostic tools, said Dan Schultz, deputy director of the FDA office that reviewed the device. According to Schultz, the main advantage is in how the pill travels the entire length of the small intestine. Current technology is more limited, generally able to visualize only the upper part of the intestine.

A doctor administers the prescription-only camera-pill to the patient, who then goes about his day: Walking and activity are encouraged to help the pill move through the system. Twenty-four to 48 hours later, the doctor simply downloads into a computer the images from the receiver worn by the patient.

The camera-pill won't replace colonoscopies, the exams that check for colon cancer, because its battery doesn't last long enough to get to the large intestine. Nor can it be used for persons known or suspected to have intestinal obstructions, including problems called fistulas or strictures, because the pill might get stuck.

But patients with anemia and unexplained blood in their stool might be candidates for the camera-pill when a standard endoscopic exam can't diagnose the problem.

The pill, called the M2A Swallowable Imaging Capsule, is made by Israel-based Given Imaging Ltd. An unidentified spokesperson for the firm said the capsules are available at a cost of $450 each. Doctors who wish to use the camera-pill in conjunction with their diagnostic exams will have to buy a $20,000 computer workstation.

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ACTIVISTS continued from page 1

are hidden taxes on manufacturing," warned Jonathan Hill. "Consumers will ultimately pay the price, through reduction of services and lack of availability of life saving drugs."

Hill reminded the hearing's participants of the importance of pharmaceutical manufacturing in North Carolina. "Senator Purcell, I was in Laurinburg last week at one of our meetings with 250 people. Their number one concern was the loss of hundreds of pharmaceutical jobs in Scotland County. Representative Wright is exactly right about the importance of manufacturing jobs in North Carolina: 42,000 jobs."

Restricting access to prescription drugs destroys incentives for innovation, creates supply shortages, and limits consumer choice—all of which would cripple the state's pharmaceutical industry. "When was the last time a new drug was developed in Canada?" asked Hill, noting that country's tight price controls over prescription drugs.

> **"Three states—California, Florida, and New Mexico—have already adopted supplemental rebate programs. Many others are considering them."**

A Battle Lost

While the fate of prescription drug controls in Maryland and North Carolina remains to be seen, CSE activists had to admit defeat in Oregon last summer.

Despite the Oregon chapter's repeated warnings about the negative consequences of prescription drug price controls and formularies, the state legislature—on the last day of the 2001 legislative session—passed HB 3300, the Oregon Prescription Drug Formulary Plan.

"HB 3300 is going to establish price controls on prescription drugs sold in Oregon and create another bureaucratic agency," explained Russ Walker, Oregon CSE director. "Worst of all, this bureaucratic agency, called the Health Resources Commission, will group similar drugs together and then recommend that the cheapest of the drugs be prescribed in nearly all circumstances. Plain and simple, there is no choice and no competition within this bill."

Oregon CSE was the only grassroots organization to fight against the formulary plan. Through frequent club and town hall meetings, the group educated and mobilized a grassroots army. The height of the mobilization occurred on Oregon CSE Day at the Capitol, when over 200 activists stormed to lobby legislators on the bill and other core issues. Over 400 individual lobby visits were conducted.

In the end, Walker predicted, "With additional resources, we could have put up a stronger fight, involved more Oregonians, and possibly changed the outcome of this piece of legislation." He urged activists in Oregon and across the country to "remain vigilant, get involved ... and never give up."

The War Goes On

In Minnesota, the annual budget bill lawmakers sent to Gov. Jesse Ventura (I) calls for the state's Medicaid program to develop a list of more expensive drugs and require physicians to get approval from state health officials before prescribing them. Drug makers could essentially "buy their way" off the restricted list by providing the state with additional price discounts for Medicaid beneficiaries.

Ventura had vetoed the overall budget proposal, which included the drug list provision, but state lawmakers are working to override the veto. Even if they are unsuccessful, the drug measure is expected to resurface in a later compromise bill. Minnesota officials estimate the restricted list, which will likely target about 10 classes of drugs, would save the state roughly $1.5 million in the first year.

Similar bills restricting access to pharmaceutical drugs were introduced in some 20 states in 2001-2002, and many were pending at the time this issue of *Health Care News* went to press. Often introduced by legislators claiming they would help reduce the rapid rise in Medicaid spending, experts warn the bills would have the opposite effect.

Medicaid rebates force pharmaceutical manufacturers to reduce discounts offered to HMOs and other group purchasing groups, causing prices to rise for persons not eligible for Medicaid. This leads to higher insurance premiums, which in turn cause some people to lose their private insurance coverage. The Congressional Budget Office reports that every 1 percent increase in the cost of health insurance causes 200,000 people to drop their coverage.

Discouraging access to drugs also has the unintended consequence of making other, often more expensive, types of health care necessary. Hospitalizations and surgeries that could have been avoided by medication mean overall spending is higher, not lower, thanks to drug price controls.

> **"Unless health care consumers organize and make their voices heard, the war against life-saving drugs will continue ... posing a genuine threat to the health of millions of Americans."**
>
> Joe Bast, President
> The Heartland Institute

"Opposition to drug price controls is poorly organized and funded in most states," says Joseph Bast, president of The Heartland Institute, publisher of *Health Care News*. "Unless health care consumers organize and make their voices heard, the war against life-saving drugs will continue ... posing a genuine threat to the health of millions of Americans."

Diane Carol Bast is vice president of The Heartland Institute and editor of Health Care News. *Jason M. Thomas is staff economist with Citizens for a Sound Economy.*

Building the Twenty-First Century Hospital

BY JANA J. MADSEN

The only thing changing more than the weather this time of year is technology. The rapid developments made recently in high-tech health care are revolutionizing hospitals through advancements in medicine, surgical techniques, and computerized procedures.

Although technology is the most obvious driver of health care facility design changes today, others include an increased sensitivity to patient and family; a desire to provide amenities, services, comfort, and convenience; and the realities of limited reimbursements.

In with the Outpatient: Trend #1

With the invention and approval of minimally invasive surgeries, patients increasingly find themselves walking in and out of the hospital in the same day. Surgeries that once spanned a doctor's entire shift have been simplified by modern technology. Because these surgeries are less straining on patients' bodies, recovery times are shorter.

What does this mean for health care facilities nationwide? Fewer beds. According to the AHA Annual Survey Database, outpatient visits were up 20.3 percent in 1998, compared to 1994.

Due to great strides in telemedicine, and its ability to transport critical patient data effectively and at lightning speeds, many small outlying or suburban hospital facilities have become largely diagnostic and outpatient-oriented.

"The hospital infrastructure has gone through a major rethinking of space allocations," says Andrew Alt, vice president and project executive for Jeffrey M. Brown Associates Inc. in New York City. Areas that previously functioned as medical records rooms, darkrooms for x-ray development, etc. have all but vanished, driven into obsolescence by the computer and the Information Age.

Flexibility and Efficiency: Trend #2

As times change, so does technology. With so many new developments coming to light every day, health care facilities must be ready to accommodate whatever the future holds. As reimbursements become tighter and tighter, not only is flexibility paramount, but efficiency is key.

"One of the things that's happening as a result of the staff efficiency issue is ... an erosion of departmental boundaries. We're beginning to see hospitals designed around the clinical pathway of the patient," says H. Ralph Hawkins, executive vice president of HKS Inc., Dallas.

By designing facilities so that medical support services are in close proximity, patients will not be routed all over the hospital for treatment. When staff is cross-trained, personnel can be utilized in more than one area during downtimes, maximizing their ability to provide quality care in the most efficient manner.

> **"As times change, so does technology. With so many new developments coming to light every day, health care facilities must be ready to accommodate whatever the future holds."**

While it is impossible to predict with certainty what is on the horizon for health care, providers everywhere are leaning on facilities professionals to do just that. The design of new facilities must be more flexible than the hospitals of old. Universal patient rooms, designed to accept any type of patient at any time, are proof of this.

According to John L. Castorina, vice president of RTKL Associates Inc. in Irving, Texas, "Acuity levels are getting higher, so we're trying to design patient care areas to be flexible enough to handle any profile of patient at any time." Larger, single-patient rooms are becoming the standard and are fitted with the equipment and services necessary to treat varying acuity levels.

HOSPITAL continued on next page

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HOSPITAL continued

Home-Like Environments: Trend #3

Click your heels together three times and repeat, "There's no place like the hospital."

Okay, so going to the hospital isn't exactly a trip to the Land of Oz. It's cold; it's sterile; it's uninviting—right? *Wrong!*

Health care facilities today are doing as much as possible to nullify this stigma, including taking hints from the other commercial buildings industry that considers "home away from home" its motto: hospitality. "Nobody seems to hesitate going into the lobby of a nice hotel," says C. Daniel Wardrop, director of health facilities for Morris Architects in Houston.

The following characteristics have been shown to increase the level of comfort for both patients and their families:

- low-wavelength colors that have a calming effect;
- differentials in ceiling heights in both public spaces and patient rooms;
- views into exterior courtyards and gardens;
- larger windows;
- single-patient rooms instead of semi-private units;
- upholstered furniture, such as three-seat couches and loveseats;
- plants; and
- aquariums.

A patient's healing process depends heavily on a number of caretakers: doctors, nurses, and loved ones. "The family, being an extension of the patient, has become more and more important [in the design of health care facilities]—as it should have been all along," says Richard L. Miller, a principal with Earl Swensson Associates Inc. in Nashville. Resource centers and Internet hookup capabilities provide families with the post-operative or post-treatment education needed to ensure quality care once a patient is released. Visitation hours are being extended to accommodate the hectic schedule of today's society, while overnight stays by family are not only common, but welcome.

One-Stop Medical Shopping: Trend #4

Perhaps taking a cue from corporations that lure the best and brightest employees with an on-site Starbucks, hospitals and health care facilities are providing patients with amenities and services that hinge on the big "C": convenience.

The patient stopping in to have a sprain x-rayed can check e-mail or access the Internet at a computer station; drop the kids at the on-site daycare center; grab a cup of coffee; view a traveling art exhibit; and skim through the latest bestsellers at the library ... all while waiting to meet with the doctor. Some innovative providers are even distributing pagers to waiting patients.

According to Castorina, "[Patients] don't want to leave the waiting room because they are afraid to lose their space in the queue. If you give them the ability or empowerment to go out and do other things—experience other things—maybe it will [remove] the intimidation of what they are about to go through."

Not only are you able to Fed-Ex packages and stroll through exterior gardens during your visit, you may also experience a taste of holistic medicine. "We're seeing almost a spa-type development in some of these facilities—where you can do anything from a massage to aromatherapy," says Swensson Associates' Miller. Too bad you have to check in to check it out, huh?

High-Tech Health Care: Trend #5

Patients are more demanding, pickier, and better informed. The doctor's word is not "as good as gold," and many patients are seeking a second opinion ... online. "The health care industry is waking up and realizing that they've got a new consumer now," says Bradley T. Barker, senior vice president at RTKL Associates Inc. This new consumer has been watching TV and surfing the Internet: He/she is a more educated patient and therefore expects more.

Because of advancements in technology and the recent strides of telemedicine:

- Patient stays have decreased in length, benefitting hospitals in a time when reimbursement is limited.
- Hospitals are maintaining a competitive edge and quality care.
- Small facilities are able to get diagnostic and treatment suggestions from mainframe hospitals and specialists quickly and efficiently.
- Monitoring of an individual's heartbeat and breathing rate can occur in the home, reducing unnecessary patient visits.
- Files and films can be organized digitally/electronically, allowing staff quick and easy access to patient data while reducing paper storage requirements.
- Pre- or post-operative education is provided online.

Techno-savvy providers are offering the latest in technology, despite the expense. "One of the problems is cost. With the minimally invasive video monitoring, companies are starting to lease this equipment because the technology is changing so fast," says Debbie Cameron, executive vice president of EQ International in Irving, Texas.

Telemedicine is an extraordinary means for communication and requires adequate technology and networking. "If the wiring closets aren't large enough, if the right pieces of telecommunications information systems equipment aren't bought, if you can't get the services from your local public utility, then you can't do it because there's no way to send information on to someone else," says Vyoyan B. Cothron, director of telecommunications, information systems, and engineered systems design at EQ International's Dallas office.

No End in Sight

Hold on to your hats: The winds of change are gusting through health care facilities nationwide. Tomorrow's forecast calls for more of the same: technology-driven designs, patient and family-focused care, and warm environments filled with all the best of today's modern conveniences.

Jana J. Madsen (jana-madsen@buildings.com) is senior associate editor at Buildings *magazine.* *This article is reprinted with permission from the November 2000 issue. Additional information about* Buildings *magazine can be obtained online, at www.buildings.com, or by phone at 319/364-6167, extension 5023.*

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Author: Medicare Faces Midlife Crisis

Medicare's Midlife Crisis
by Sue A. Blevins
President, Institute for Health Freedom

REVIEW BY CONRAD F. MEIER

"Midlife crisis" is the term given to the feeling many of us get around age 40: a fear that our time on this Earth is running out. This is a fair description of Medicare, a socialized health care experiment whose time is running out.

Some psychology experts don't acknowledge the existence of a "midlife crisis." They suggest at around age 40 we become aware of an unidentifiable gnawing concern or dissatisfaction with the way things are ... but no crisis. That, too, could also describe Medicare, born in 1965 of a liberal desire for national health care, and now dysfunctional in the twenty-first century.

"If you have an interest in Medicare by virtue of your profession or your age, you should read this book. If you have no interest in Medicare, you *really* need to read this book, before you too are trapped in government-run health care."

In *Medicare's Midlife Crisis*, Sue Blevins explains, in almost John Grisham detail, the fascinating, almost clandestine background of how Medicare came about: who was singularly responsible, how details were hidden from the public, and why there was no review or balanced discussion on the legislation. If you think the Enron tale makes interesting reading, try reading *Medicare's Midlife Crisis* for a satisfying dose of conspiracy, manipulation, and fraud.

All About Politics

The book is organized into six chapters:

- an introduction to Medicare and broad overview;
- an examination of the history of health care in the United States and early efforts to impose single-payer health care;
- a discussion of the evolution of Medicare and the political climate at the time;
- a look at how government officials hid the true cost of the program during its early stages;
- an analysis of the Medicare program's costs since 1965; and
- ideas for reform.

Blevins clarifies why Congress created three separate government programs—Medicare Part A, Medicare Part B, and Medicaid—and who benefitted the most from this approach. Clue: It was not consumers. Blevins writes, "Combining the three programs would make it appear as though Medicare were voluntary and that seniors would have access to private health insurance."

Of the many surprises in store for readers are the factual and little-known consequences of the Medicare mandate. Anyone who declines Medicare Part A, for example, forfeits all claim to earned benefits under years of payments to Social Security. Part B, while allegedly "voluntary," traps citizens by increasing the premium 10 percent a year for every year a citizen delays enrollment beyond age 65.

Because of these forced incentives, senior citizens can no longer access a private, individual insurance market for full health insurance coverage—that market has gone the way of dinosaurs, killed by the government's desire to have a monopoly over senior care. Moreover, cash no longer works either. Congress has made it illegal, with stiff financial penalties and up to 10 years in jail, for any doctor who accepts Medicare patients to take money for services provided to eligible but non-Medicare patients.

Blevins explains how seniors now pay nearly as much of their income for out-of-pocket medical costs as they did before Medicare. She notes that despite the massive financial resources taxpayers pay into the system, many retirees discover (usually too late) that Medicare does not cover catastrophic illness, nor does it cover long-term care.

So why do we have a restrictive government-run health plan for seniors, when private alternatives would be cheaper?

Blevins suggests one answer is politics: "Politicians gained too, by creating a government program that personally affects a very large and powerful voting constituency. Today, many politicians seek seniors' votes with the promise to expand benefits while [keeping] Medicare solvent."

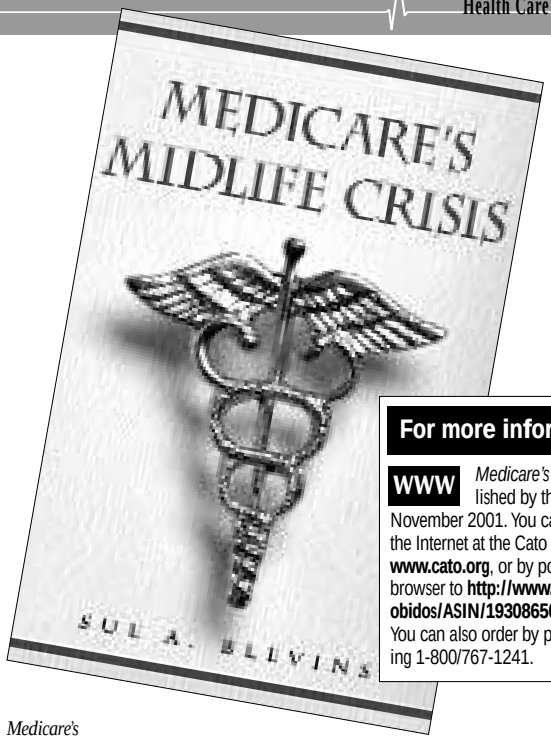
No Panacea, Just a Plan

The book does not offer a panacea for fixing the problem. "Rather," writes Blevins, "in order to cure the problems we face with Medicare, we need to first establish a diagnosis."

Nevertheless, she does offer up a reform proposal. She presents the work of Andrew Rettenmaier and Thomas Saving, both economists at Texas A&M University, who have developed a proposal to transition pay-as-you-go Medicare to a program that relies on fully funded medical accounts owned by individuals. I won't give away the plot here, so please go to Chapter 6, "Reforming Medicare in the 21st Century."

Any book worth the price of admission has to deliver something of value. In the case of *Medicare's Midlife Crisis*, readers get their money's worth in an overview of how Medicare affects the public today and how, if not reinvented, it will burden health care users, both financially and emotionally, 30 years from now.

If you have an interest in Medicare by virtue of your profession or your age, you should read this book. If you have no interest in Medicare, you *really* need to read this book, before you too are trapped in government-run health care.

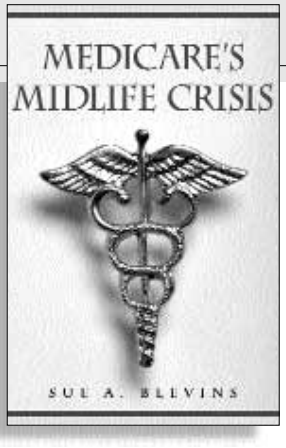


For more information…

WWW *Medicare's Midlife Crisis* was published by the Cato Institute in November 2001. You can order the book on the Internet at the Cato Institute's Web site, **www.cato.org**, or by pointing your Web browser to **http://www.amazon.com/exec/obidos/ASIN/1930865082/theheartlandinst**. You can also order by phone, toll-free, by calling 1-800/767-1241.

"If you think the Enron tale makes interesting reading, try reading *Medicare's Midlife Crisis* for a satisfying dose of conspiracy, manipulation, and fraud."

"Sue Blevins has presented the finest and most accurate history of Medicare that I'm aware of."
–Dr. Edward Annis, past president, AMA



Medicare's Midlife Crisis
by Sue A. Blevins
128 pages, cloth $16.95, paper $8.95

Most Americans know little about Medicare even though they rely upon it. Sue Blevins examines the program's origins, its evolution, and future policy options to reform it, including consumer choice. The cost of Medicare today far exceeds what the costs were expected to be when the program was created 35 years ago. Although the recent prosperity extended the life of the program, it faces insolvency in the near future, and efforts to reform the program and cut its costs have been stymied. This book helps explain how we got into the mess we face today.

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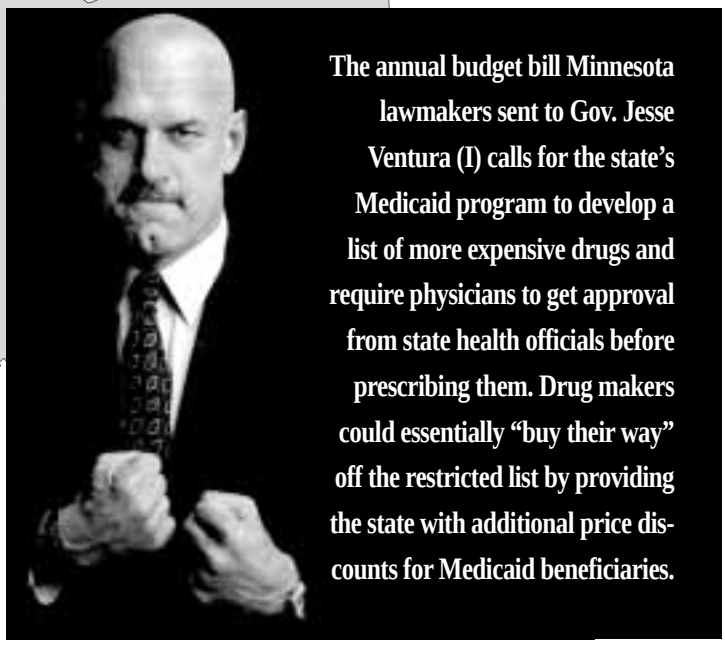
State Legislative Update

COMPILED AND EDITED BY CONRAD F. MEIER



The annual budget bill Minnesota lawmakers sent to Gov. Jesse Ventura (I) calls for the state's Medicaid program to develop a list of more expensive drugs and require physicians to get approval from state health officials before prescribing them. Drug makers could essentially "buy their way" off the restricted list by providing the state with additional price discounts for Medicaid beneficiaries.

ARIZONA

Arizona's Statewide Health Care Insurance Plan Task Force is drafting a proposal to provide health insurance to the state's one million uninsured residents within the next three to five years. The task force, made up of three state senators, three state representatives, and three community members appointed by Gov. Jane Hull (R), worked on the proposal with a 14-member technical advisory panel of hospital, state agency, and insurance company representatives.

The proposal has been in the planning stages for the past two years and now is moving toward final planning and implementation.

FLORIDA

The Florida House appears poised to approve measures for expanding the number of insured residents by allowing insurance companies and other groups to sell low-cost, mandate-free health plans. The plans would be exempt from state coverage mandates known to influence premium inflation. In Florida there are 51 mandated benefit areas, including mammograms, HIV-related treatment, and certain emergency care services.

The "health-flex plans," according to insurance industry lobbyist Sam Miller, could be 30 to 40 percent less expensive than traditional health plans and would offer another option to uninsured Florida residents who earn too much to qualify for Medicaid or who opt-out of employer-based coverage because they cannot afford their share of the premium. The state House is considering two measures that would establish the health-flex plans. Gov. Jeb Bush (R) backs the plan. One of the two bills, HB 913, was "tentatively approved" by the House March 7. It would allow small businesses around the state to offer their employees the health-flex plans.

HAWAII

Hoping to provide a partial solution to rising health care costs, a Hawaii business is set to launch an alternative to an employer-based plan that will provide the uninsured with access to certain discounted medical services for a monthly fee.

Under the DirectCare plan, created by the international trading and consulting firm Dawson International, families will pay $35 a month and individuals will pay $20 a month for annual check-ups and 25 percent discounts on other services if they pay by cash or credit card at participating physician offices at the time of the visit, according to Don Dawson, the company's founder and president.

Dawson said both consumers and doctors are eager for an alternative given the state's rising health costs. "The health care industry in Hawaii is in turmoil. Physicians are spending too much money and time on processing claims and accounts receivable and fighting ever-decreasing reimbursements," he said.

MAINE

Maine Senate President Richard Bennett (R) has proposed the Maine Consumer Choice Health Plan. If enacted, the bill (LD 2146) would create a state health insurance purchasing pool, expanding the types of health coverage available to residents and public and private employers at a broad range of price points.

Bennett's proposal is modeled after the Federal Employees Health Benefit Plan. A five-member board of directors would negotiate health plan contracts with a number of insurance carriers. Private and public employers and individuals who have not enrolled in other health plans would be eligible for health plans offered under the program.

According to Bennett, 1.1 million residents would be eligible to participate in the program. Bennett said that "the bill, which is backed by such groups as the Maine Medical Association and the Maine Hospital Association, provides health insurance options for all Mainers, regardless of income, employment status, employer or location."

MINNESOTA

Gov. Jesse Ventura (I) vetoed the annual budget bill sent to him by state lawmakers. The bill included a provision calling on the state's Medicaid program to develop a list of drugs physicians would not be permitted to prescribe without prior approval from state health officials. State lawmakers are working to override Ventura's veto. (See "Grassroots Activists Take on Rx Limits," page 1.)

MISSISSIPPI

Mississippi Gov. Ronnie Musgrove (D) signed two bills covering most of the state's $158 million Medicaid budget deficit until the end of the fiscal year on June 30, 2002. Musgrove signed the legislation just hours after it was approved by the legislature. The measures will cover all but $29.5 million of the budget shortfall. Additional cuts will need to be made over the next few months. Some lawmakers warned the legislative fixes were "not well planned" and would provide only a temporary solution.

MISSOURI

Missouri legislators and child-advocacy groups asked the state senate's Public Health and Welfare Committee to support a bill that would extend the state's CHIP program through 2007. Benefits under the program are set to expire July 1, 2002.

The $62 million MC+ for Kids program is a Medicaid-expansion program that covers children in families with annual incomes up to 300 percent of the federal poverty level. Currently, about 77,000 children are enrolled in Missouri's program, which costs the state about $17 million per year. State Sen. Ed Quick (D) presented SB 1111, which would extend the program and maintain its current eligibility standards for five more years.

Although no one testified against Quick's bill, Missouri's CHIP program has been criticized by some lawmakers for its high income eligibility limits. State Rep. Patrick Naeger (R) has introduced HB 1346, which would reduce CHIP program eligibility for new applicants, covering only those children in households earning up to 225 percent of the federal poverty level. In testimony, Naeger said, "Medicaid, for goodness sakes, is an entitlement for the poor and the indigent. It's not a free way to health care for anybody willing to pay a small premium or anybody too lazy to put their kids on their plan at work."

NEVADA

Gov. Kenny Guinn (R) has indicated a "dramatic" increase in Medicaid's caseload may force the state to delay scheduled program expansions. While Guinn did not indicate what service enhancements would be delayed, a breast and cervical cancer screening benefit for uninsured women, as well as reimbursement increases for providers, could be among the cutbacks.

In response to the caseload increase, the Legislature's Interim Finance Committee—which can make budget changes even though lawmakers are currently out of session—met February 5 to examine the program's enrollment and projections.

TENNESSEE

A federal judge ruled Tennessee is not required to use more than $100 million of its tobacco settlement funds to pay for smoking-related injuries through TennCare and was within its rights to use the additional money to balance the state budget. The decision stems from a lawsuit filed by two members of TennCare, the state's Medicaid managed care program.

The suit claimed the program was required to compensate the members for tobacco-related medical expenses before lawmakers could appropriate tobacco settlement funds for other budgetary purposes.

Ruling on the preliminary injunction request, U.S. District Judge Aleta Trauger said, "The state and the public ... would be harmed if the state is denied the use of the funds." She added that beneficiaries with tobacco-related illnesses were free to sue tobacco companies for medical expenses.

The State Legislative Update is compiled from a wide range of news sources, including the Council for Affordable Health Care (CAHI) http://www.cahi.org; the National Association of Health Underwriters (NAHU) http://nahu.org; Bizjournals at http://bizjournals.com; Stateline at http://stateline.org and Lexis/Nexis research.

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THE GALEN REPORT

A monthly review of health policy matters

Senior Capitol Hill staff members outlined prospects for passage of a Medicare prescription drug benefit this year during an April Commonwealth Fund conference on "Options and Possibilities."

Julie James of Health Policy Alternatives gave an excellent overview of drug coverage options, from competing private plans (Thomas, Breaux/Frist), to a drug benefit add-on for existing Medicare (Daschle, Graham), to drug cards (Bush, Galen Institute), to a "benefit swap" (Senate Finance 2000) that would allow people to select a redefined comprehensive benefit package for Medicare that includes prescription drugs.

John McManus, staff director of the House Ways and Means Subcommittee on Health, said the House leadership wants a vote on a drug benefit bill by the end of May to give the Senate time to pass a bill of its own. He outlined areas of agreement with Democrats, including making sure the benefit provides assistance for all Medicare beneficiaries, with special subsidies for those with low incomes, and assuring government will serve as a back-up so plans or other options are available in all areas of the country.

Further, McManus said there was basic agreement on the cost of a benefit: $350 billion for the House and $400 billion for the Senate ($500 billion budgeted, minus $100 billion for the uninsured).

Liz Fowler, chief counsel on health for Democrats on the Senate Finance Committee, agreed that, "Once you get to agreement on costs, it is easier to get a bill." She also said Democrats are comfortable with the concept of prescription drug management firms and the need for incentives for efficiency. But she said the structure of the program would need to track current Medicare benefits, with a government-defined benefits package, low deductibles, and small co-payments on drugs. Fowler said Senator Charles Grassley is leading a tri-partisan group of Senators to develop a Senate bill.

Patrick Morrissey, deputy chief of staff for the House Energy and Commerce Committee, focused on the problems involved in new federal funding for state-based programs, as the Bush administration has recommended, "which make it more difficult to reform the program in the long run" and may drain resources from those who need help the most.

Our perspective: Democrats and Republicans are too far apart to come to agreement on a drug benefit this year; there is too much political capital in play to take this off the table as an election issue; and senior citizens are simply not educated enough about their options for Washington to be spending this kind of money. If Congress acts without properly educating seniors about the options and trade-offs, they could be faced with a repeat of 1989's Catastrophic Coverage failure.

Some good news from the West Coast: California Governor Gray Davis and Republican challenger Bill Simon squared off recently in a debate before the California Medical Association. Davis defended the status quo. Simon called for "wholesale changes," including "tax incentives that will empower individuals to seek the care that is right for them."

"We have the finest hospitals, physicians, and nurses the world has ever known, but you're mired in a system that doesn't work. We need fundamental reform, and let that process begin with this campaign between Gray Davis and me."

Simon's bold and visionary speech earns three cheers. You can read it at http://www.simonforgovernor.com/showArticle.php?id=380

As California goes ...

— Grace-Marie Turner

RECENT PUBLICATIONS

Racist Doctors? Don't Believe the Media Hype

Sally Satel

Wall Street Journal, 4/4/02

"The institute's case for prejudice in the March 20 report is weak," says Dr. Sally Satel in response to the recent Institute of Medicine report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care." The report identified racism as a major culprit in perceived health disparities of minorities.

Satel identifies the lack of investigation of the underlying causes of differential care to be a major problem of the IOM report. Unanswered questions remain, such as whether black patients refuse treatment more often than white patients, whether black patients have higher rates of other conditions that would prohibit treatment, and the marriage rates of black patients.

"All the hype surrounding the study is most disturbing because it diverts us from the far more important causes of the health gap: access to care, health literacy, and attitudes toward health. We can do much to improve the health of African-Americans. Inciting their distrust of the medical profession with misleading claims about physician prejudice can only hurt," Satel said.

Full text of article: http://www.galen.org/news/040402.html

The Medicare Police

Wall Street Journal, 4/1/02

Layers of regulations, price controls, and coverage limits added by Congress have not been able to control costs in the Medicare program, says the *Wall Street Journal*. Instead, these confusing, overbearing regulations have led to a misguided campaign by federal prosecutors to find fraud in the program. Innocent doctors are dropping out of the program for fear of criminal investigations.

The *Wall Street Journal* recommends the Medicare program be reformed to introduce market-based competition into the system. "The cause [of Medicare reform] needs to be revived, especially with politicians clamoring to add drug benefits to a broken system. America's medical profession needs to be liberated from red tape and the Medicare police."

Full text of article (requires subscription): http://online.wsj.com/article/0,,SB10176240509 15409400,00.html

Prescription Drug Payola

Merrill Matthews Jr., Ph.D.

Institute for Policy Innovation, 3/12/02

The old payola scam has reappeared, but this time it is prescription drugs, not radio airplay, says Merrill Mathews of the Institute for Policy Innovation.

Drug manufacturers are being told by government officials and politicians that the only way the poor will be given access to the companies' drugs is if each company hands over additional cash. Matthews says they are essentially telling the drug companies, "If you want the poor to have access to your product, cross my palm!"

Louisiana's Department of Health and Hospitals exemplifies the new version of payola. It recently contracted Provider Synergies to negotiate state rebates drug companies agree to pay in return for getting their drugs on a list for Medicaid reimbursement (*The Advocate*, 4/4/02). Matthews points out that supplemental rebates are merely an attempt to generate revenues without raising taxes and asks, "Wouldn't it make more sense to let competition, rather than rebates and price controls, drive costs down?"

Full text of article: http://www.ipi.org/ipi/IPIPublications.nsf/PublicationLookupFullText/ECBC26550DB51EA686256B89006A8280

Changes in Insurance Coverage: 1994-2000 and Beyond

John Holahan and Mary Beth Pohl

Health Affairs, Web Exclusive, 04/03/02

New data from the Current Population Survey for 2000 shows that between 1994 and 2000, lower-income Americans were likely to move up the income scale and get jobs that provided health coverage, while middle-income Americans were net losers in health insurance coverage.

In 1999 and 2000, there was a significant shift among children below 200 percent of poverty from private coverage to government programs, showing the shift from private insurance to the State Children's Health Insurance Program among lower- and middle-income children.

While the rate of uninsured was virtually unchanged during the period, there were significant shifts within the population. "A major change took place in the income distribution. ... There were fewer low-income Americans, but those whose incomes stayed low were more likely to have employer coverage," the authors write.

The net loss of health insurance coverage by middle-income Americans could signal a major shift in the debate over the uninsured as this more politically powerful constituency feels the pinch of a system that needs repair.

Full text: http://www.healthaffairs.org/WebExclusives/Holahan_Web_Excl_040302.htm

Material for this report is provided by The Galen Institute, P.O. Box 19080, Alexandria, VA 22320, http://www.galen.org. Grace-Marie Turner is president. This report is produced by Elizabeth Lamirand, who can be reached at 703/299-9550, and edited by Conrad F. Meier, managing editor of Health Care News.

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MY TURN BY CONRAD F. MEIER - MANAGING EDITOR

Not in My Backyard

Given the evidence presented in our series on England's socialized medical system, it should not be difficult to question the merit and morality of duplicating such a flawed arrangement in the United States.

If there is any lesson we can learn from the beleaguered National Health Service (NHS) and the failure of single-payer health care, it must be that centralized planning and control never was a workable alternative to market pricing, private-sector innovation, and consumer rights.

Meet the Enemy

If you think proposals for single-payer health care in this country are just the harmless rantings of a few out-of-touch socialist thinkers, please read on and reconsider.

The unending pro-single-payer public relations campaign, produced by a well-funded and varied group of health care activists, does not disturb me from the standpoint of free speech. They have every right to say what they want to say.

Their rhetoric is troubling, however, because it is a deceitful attempt to impose the will of a self-anointed elite on the majority of Americans who, in my opinion, are mostly unaware of the enemy within.

A short list of Who's Who in the push for socialized medicine includes the determined likes of the Universal Healthcare Action Network (UHCAN); Families USA - Health Action 2002; Physicians for a National Health Program; Greenpeace (!); Democratic Socialists of America; Votehealth.net; the Labor Party; American Federation of Teachers - AFL-CIO; Center on Budget and Policy Priorities; Communications Workers of America; Children's Defense Fund; Easter Seals; Consumers Union; Gray Panthers; Service Employees International Union - UAW; and the liberal-minded politicians who vote in lockstep for statist health care plans.

(For a growing list of co-sponsors of Health Action 2002, see http://familiesusa.org/html/conference02/cosponsors.htm)

"If there is any lesson we can learn from the beleaguered National Health Service (NHS) and the failure of single-payer health care, it must be that centralized planning and control never was a workable alternative to market pricing, private-sector innovation, and consumer-rights."

Seeking the Truth

The propaganda produced in support of single-payer health care ignores the truth and is designed to motivate people through the use of scare tactics; distorted and often fabricated information; and undocumented facts and figures on how much such a plan would cost in premiums, income taxes, lost state revenue, job dislocation, individual freedom, and human suffering. (See "Maryland Single-Payer Proposal Would Cost 117,000 Jobs, Shrink Payroll Tax Receipts by $4.89 Billion," *Health Care News*, January 2002.)

No domestic advocate of socialized medicine has yet explained why they support a plan of medical care access that has been proven to fail daily in its promise to provide affordable quality medical care for everyone ... the very goal they allegedly seek. Why do these health-care gurus ignore the irrefutable experiences from Britain, Canada, and other socialized systems?

No Bang for the Big Bucks

One lesson we can take from the British and Canadian experiences is that those with political clout, high social status, and sufficient personal wealth are assured of either getting the best care first, or buying their way out of government-run care entirely by going to a market-based health care system in another country ... quite often the United States.

Another lesson is one of economics. The evidence demonstrates without doubt that socialized medicine is inefficient and more expensive than the free-market alternative. It produces an environment in which people think their care is free. The resulting moral hazards, unsustainable consumer expectations, and frivolous use of medical services are legendary.

England's single-payer health care plan has turned into a tax burden far worse than what we've experienced to date in this country. The burgeoning costs—in the form of high income taxes, insurance taxes, premiums, lower wages, reduced productivity and job opportunities, plus extra fees and hidden taxation—have become a stranglehold on middle- and low-income consumers.

The government that controls health care controls everything. What control might the government exercise over a citizen who disagrees with the ruling powers and their line of thinking? Will he or she simply be denied or rationed care necessary to stay alive and active? This is not merely a hypothetical question: It has happened in other countries and, if the proponents of socialized medicine remain unchallenged by those of us who see the danger, it can happen again ... right here in our own backyard.

Not Perfect, Only the Best

Our health care freedoms must be cherished as highly as all the other liberties defended explicitly by our Constitution and Bill of Rights.

This is not to suggest our current system is perfect. *Health Care News* regularly covers many of its faults, and we'll continue to do so. We also offer suggestions for workable reform, within the context of protecting and *enhancing* the competition and consumer choice that make our system better than the rest.

Medical savings account (MSAs), defined contribution health plans, tax credits, Medicare and Medicaid reform, and tax-favored long-term care insurance—reforms that receive constant attention in *Health Care News*—all serve to reduce government influence, protect our privacy, empower the consumer, restore the patient-doctor relationship, and bring us closer to an American brand of universal health care.

If we settle for anything less, someday, someone, somewhere will write a column describing our health care system as the clone of the NHS. And he won't mean that as a compliment.

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